January,

Canadian Hospital

- *Planned Spending*
- *Unions come to hospitals*
- *For routine examination*
- *In-service education in nursing*
- *Health services in the Bahamas*
- *Expansion program at Vancouver General*

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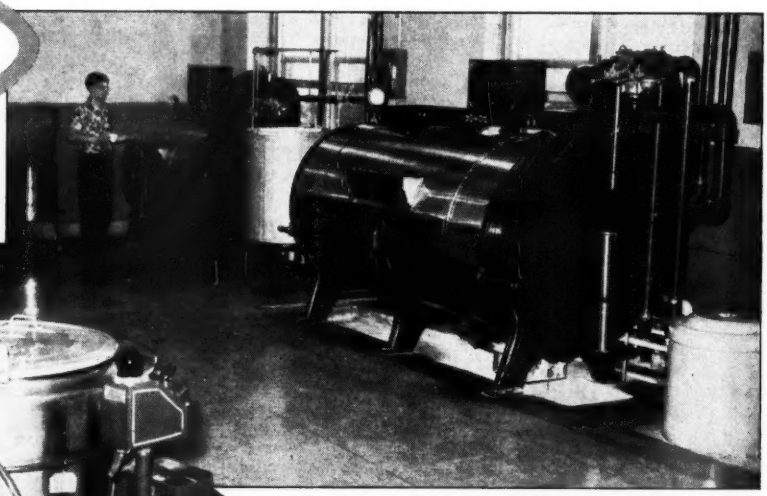

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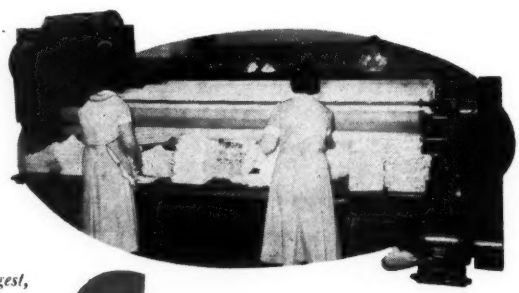

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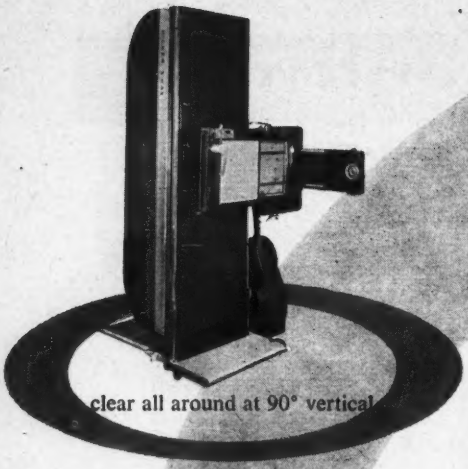

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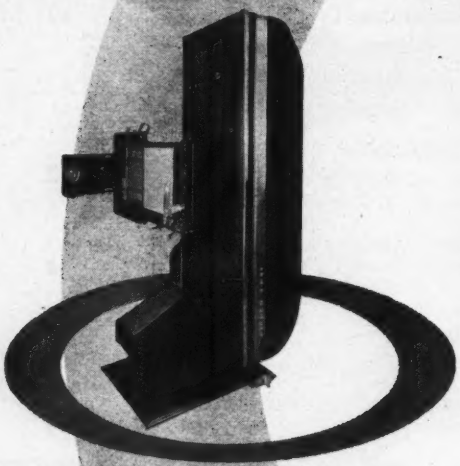

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◂ Notes About People ▸

Dr. Paul Bourgeois, a director Canadian Hospital Association

(This is the seventh of a series of biographical notes, introducing officers and directors of the Canadian Hospital Association for 1955-57.)

Dr. Paul Bourgeois, a director of the Canadian Hospital Association, has been director general of Hôpital Notre-Dame, Montreal, P.Q., since June, 1954. He is a life governor of the hospital. Dr. Bourgeois was president of the hospital's medical council from 1952 to 1954 and represented the medical staff on the board of governors from 1945 to 1954.

In 1928, he was graduated in medicine from the University of Montreal and, in 1929, received a provincial government bursary to study general surgery and urology, for three years, in Strasbourg and Paris. In 1932, he joined the staff of the urology department at Hôpital Notre-Dame, becoming chief of that department in 1943. Dr. Bourgeois became associate professor of urology at the University of Montreal in 1945 and was named professor in 1948.

In 1950, he was elected a member of the Canadian Association of Clinical Surgeons and, in 1954, he retired from his university post, becoming professor emeritus. In January 1955, he was elected second vice-president of the Montreal Hospital Council and in May, of the same year, a director of the Canadian Hospital Association.

Dr. Bourgeois is a Fellow of the Royal College of Physicians and Surgeons of Canada. He was president of the Canadian Urological Association from 1951 to 1952 and was Canadian delegate to the meeting of the International Society of Urology in 1953.

Dr. Paul Bourgeois

Traduction

Le docteur Paul Bourgeois, un directeur de l'Association des Hôpitaux du Canada, était nommé directeur général de l'Hôpital Notre-Dame à Montréal, en juin 1954. Il est gouverneur à vie de l'Hôpital Notre-Dame, fut président du Conseil medical de 1952 à 1954 et membre du Bureau d'administration de 1945 à 1954 à titre de représentant du personnel médical.

En 1928, il receivait son diplôme de médicine de l'Université de Montréal. Boursier du Gouvernement provincial de 1929 à 1932, il étudia pendant trois ans la chirurgie générale et l'urologie à Strasbourg et à Paris. En 1932, il était accepté dans le service d'Urologie de l'Hôpital Notre-Dame, service dont il devenait le chef en 1943. En 1945, il était nommé professeur agrégé en Urologie à l'Université de Montréal et en 1948, il était nommé professeur titulaire.

En 1950, il est élu membre du Canadian Association of Clinical Surgeons. En 1954, il est nommé professeur émérite de la Faculté de Médecine de l'Université de Montréal. En janvier 1955 il était nommé 2è vice-président du Conseil des Hôpitaux de Montréal et en mai de la même année, directeur de l'Association des Hôpitaux du Canada.

Le docteur Bourgeois fut l'un des premiers médecins à obtenir aprés examens, le diplôme d'associé en chirurgie générale (Fellowship) du Collège Royal des Médecins et Chirurgiens du Canada. Entre autre nominations, il fut président de l'Association d'Urologie du Canada de 1951 à 1952 et délégué canadien à la Société Internationale d'Urologie en 1953.

Mrs. A. K. Cressman

Mrs. A. K. Cressman, Waterloo, Ont., one of the leaders in the Central Council of Auxiliaries to Freeport Sanatorium, Kitchener, Ont., died recently. The council worked untiringly to strengthen the tuberculosis control program in Waterloo County and they gave active and sustained support to the Freeport Sanatorium, as well as conducting the Christmas Seal sale for several years before the Waterloo County Tuberculosis Association was formed. Mrs. Cressman was for many years treasurer of the organization. Shortly before her retirement, the Canadian Tuberculosis Association, at its annual meeting in 1954, conferred on her an honorary life membership as a tribute to her years of service in the cause of tuberculosis prevention.

* * * *

Administrative Changes at Brockville General Hospital

William J. Cooke, formerly administrator of the Brockville General Hospital, Brockville, Ont., for the past ten years, has resigned his position to accept the post of administrative officer of the North Battleford Indian Hospital, North Battleford, Sask. James Wilson, formerly administrative assistant at Victoria Hospial, London, Ont., has been appointed to succeed Mr. Cooke at Brockville. Mr. Wilson is a native of Edam, Sask., and was graduated from the University of British Columbia with the degree of Bachelor of Arts in 1951. In 1952, he enrolled in the post-graduate course in hospital administration at the University of Toronto and served his administrative residency at Victoria Hospital, London.

* * * *

New Appointment at Amherst, N.S.

Miss K. Boutilier, R.N., of Moncton, N.B., has been named superintendent of nurses at Highland View Hospital, Amherst, N.S. She succeeds Miss M. Trueman, R.N., who has filled this position for many years and was a member of the hospital's staff for over 32 years. Miss Boutilier, who took over her new duties at the beginning of December, was formerly a member of the staff of the Victorian Order of Nurses in Moncton. She has also taken special courses in administration and classroom instruction.

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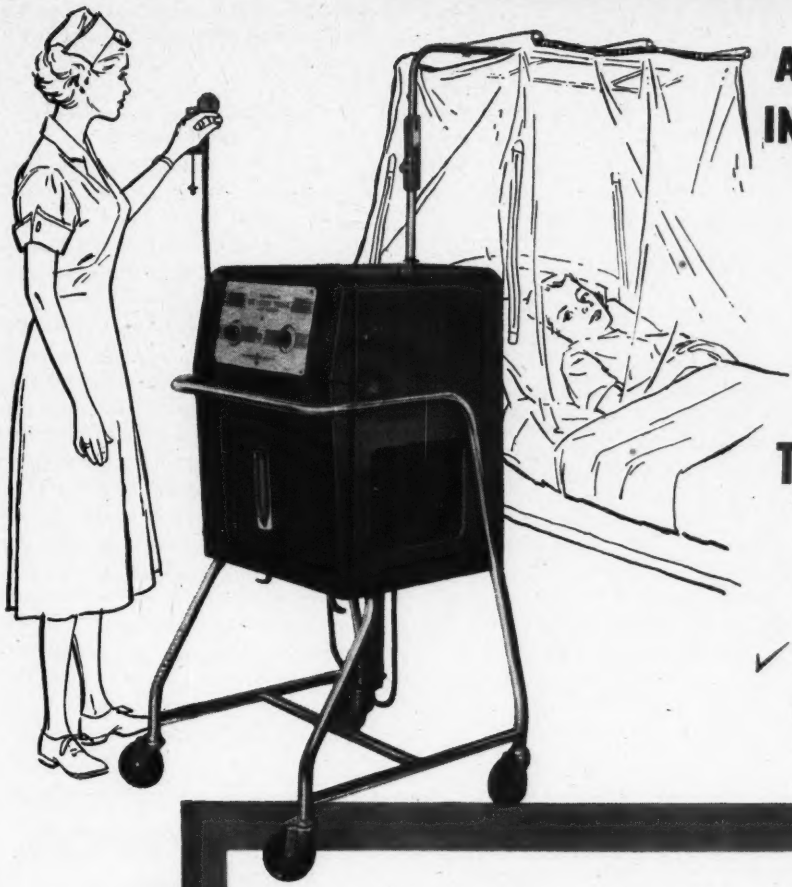

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People

(Concluded from page 12)

• Agnes Chervinski, R.N., of Lethbridge, Alta., is the new matron of MacLeod Municipal Hospital, Fort MacLeod, Alta. Miss Chervinski is a former matron of the Taber Municipal Hospital, Taber, Alta., and latterly has been on the staff of St. Michael's Hospital, Lethbridge. She is a graduate of the Edmonton General Hospital school of nursing. Miss Chervinski replaces Mrs. Ellen Hilliard, who resigned recently.

• Eleanor Sharp, R.N., of Fonthill, Ont., has been appointed superintendent of the County of Bruce General Hospital, Walkerton, Ont. Prior to her new appointment she was on the staff of the Haldimand War Memorial Hospital, Dunnville, Ont.

• Minnie Miller of Williamsford, Ont., has accepted the position of superintendent of the Chesley and District Memorial Hospital, Chesley, Ont. Miss Miller, who was formerly superintendent of the Palmerston General Hospital, Palmerston, Ont., succeeds Helen Marshall who has resigned.

• Bernard McCarthy has been appointed administrative assistant in charge of out-patient service at the Pennylvania Hospital, Philadelphia, Penn. Mr. McCarthy is a graduate of the post-graduate course in hospital administration at the University of Toronto and served his administrative residency at the Toronto East General and Orthopaedic Hospital.

• Dr. Robert Clark Dickson, who has been associate professor of medicine at the University of Toronto, has been appointed professor of medicine at Dalhousie University, Halifax, N.S., and head of the department of medicine at the Victoria General Hospital.

• Dr. Leigh J. Crozier, director of Hermann Hospital, Houston, Texas, formerly of London, Ont., was honoured recently by the interns and residents of the hospital. Dr. Henry Glass, resident in surgery at the hospital, presented Dr. Crozier with an engraved watch and stated "since coming to Hermann Hospital, in 1949, he has made a notable contribution not only to the advancement of the entire hospital but of leading importance has been his interest in and support of the medical education programs".

Federal-Provincial Discussions on Health Insurance

It has been announced by the Hon. Paul Martin, Minister of National Health and Welfare, that federal-provincial discussions on health insurance will be resumed on Monday, January 23. The forthcoming talks arose out of the October Federal-Provincial Conference at which an inter-governmental committee of health and finance ministers was established to discuss proposals put forward at that time and any others the provinces might wish to suggest. The agenda for the coming meeting includes such matters as the components of a health services program, projected costs, methods of financing, administrative aspects, and priorities in the development of the various services. The governments of all ten provinces have indicated their intention of attending and participating in the discussions.

Twenty Years Ago

("The Canadian Hospital", Jan., 1936)

"Congratulations are in order to the board of governors and the superintendent (A. J. Swanson) of the Toronto Western Hospital, architects (Govan, Ferguson, and Lindsay), and others who have participated in the building and equipping of the imposing new addition, which will add so much to the facilities of the Toronto Western Hospital"—*Edit.* The erection of the new 14-storey pavilion and the addition of a fourth storey to the main building are almost completed.

Special attention was given by the architects to the rate of heat transmission through and the heat capacity of the structural walls, together with heat loss through windows. Specially made insulating blocks were used for the backing of the walls and to this cork was added. Windows are double-glazed, caulked and weather-stripped. Lighting fixtures of high efficiency. specially designed for this hospital, reduce power consumption in some departments by about fifty per cent, as compared with standard practice. These carefully-worked-out details combine to reduce heat, light and power consumption, which is one of the few factors in hospital management, the cost of which can be lowered from accepted standards.

An unusual feature of the new building is that provision is made for heating or cooling several rooms on each floor so as to maintain them at a different temperature and humidity from the other rooms. This will be done by moving a portable unit into the room to be used and connecting it to special services provided in these rooms. It is expected that a room can be kept at least 10 degrees warmer or cooler than the general temperature of the building and at comparatively little cost; and also the humidity in such rooms can be maintained at any desired point.

Leonard Shaw, B.Sc., of Saskatoon, will assume the editorship of *The Canadian Hospital* in the near future. The reorganization plan now being effected between the Canadian Hospital Council and this Journal will bring about a new and closer relationship between the two organizations.

Some of our hospitals have recently been receiving a good deal of criticism for operating cafeterias, selling flowers, candy, magazines, and so on, to patients' relatives.

At the 17th annual convention of the Saskatchewan Hospital Association, held at Moose Jaw, October 22 and 23, "The Possible Effect of a Health Insurance Plan on our Hospitals", was reviewed in a paper by Leonard Shaw, superintendent of the City Hospital, Saskatoon. He indicated the general trend towards compulsory health insurance in over 20 countries throughout the world and the possibility of legislative control of health problems in our country in the near future. In Canada, this will be a provincial problem and in some provinces active interest is already in evidence and plans formulated.

A $2,000,000 construction program for Winnipeg General Hospital, involving additions to or replacements of existing buildings, was put before city council on December 2nd, with a request that the scheme be advanced to

(Concluded on page 80)

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Let's Show the Surveyor Every Consideration

AT THE ANNUAL meeting of the Canadian Commission on Hospital Accreditation held in Toronto, December 10th, the work for 1955 was reviewed. Some 139 hospitals were visited by surveyors, compared with 155 during 1954. Of the 139 hospitals, 76 were fully approved, 33 provisionally approved, 17 not approved, and 13 were visited but not rated. Of the surveys conducted, surveyors of the Canadian Medical Association did 111, the American Hospital Association 24, and the American College of Surgeons 4. In addition, the surveyors of the Canadian Medical Association, Dr. K. E. Hollis and Dr. J. J. Laurier, conducted 18 surveys in connection with residency training for the Royal College of Physicians and Surgeons of Canada.

All who attended the meeting of the Canadian Commission were convinced that education is a fundamental part of the accreditation program. The surveyors and the chairman of the Commission, Dr. E. Kirk Lyon, have given freely of their time in addressing meetings, *e.g.*, medical staffs, hospital conventions, and in writing articles. All this has contributed to a better understanding of the accreditation program in Canada. The review of the year's work also demonstrated that planning the itinerary for a surveyor is not a simple matter. Scheduling has to be done months in advance of the actual date that the surveyor arrives at your hospital. In Canada, with great distances to be covered, it is necessary because of travel costs that there be little or no change in the route to be taken by the surveyors once this has been finalized.

Even though the date given for the survey of your hospital is for one reason or another not the most convenient, each hospital should accept it and make every effort to comply. It should be possible, regardless of the date chosen, for any hospital to arrange for the reception of the surveyor and to have competent people provide the necessary information. Arrangements should be made in advance for the surveyor to meet certain groups in the hospital, e.g., board members, medcial staff, and administration. Not only is it in the interests of the individual hospital to do this, but it is also an act of courtesy to the surveyor which will be appreciated.

A Disaster Plan is Well Worth the Effort

THE TWENTY-NINE hospitals represented at the Toronto Hospital Disaster Institute, held December 8th and 9th, were offered no panaceas in the preparation of their own individual hospital disaster plans. Contents of the disaster manuals of the Toronto Western Hospital and the Humber Memorial Hospital, which were presented at the institute, made this very clear. Delegates who needed any further assurance on this point could come to only that conclusion after listening to the presentations of Mr. A. J. Swanson and Mr. Robert Ferguson. Both plans presented had evolved after months of meetings, co-ordination of various groups, and close attention to detail. At the opening session, Mr. Swanson emphasized that such planning must be practical rather than idealistic and this note became the theme of the institute.

The Toronto Disaster Institute was the sixth held in Canada and there are now hospital disaster plans available, as reference material, for large and small hospitals; yet each hospital must develop its own plan. That is, while the basic principles underlying all twelve plans presented have been similar and problems are confronted by each hospital which are similar to those found by others, it still remains for each hospital to fit its own plant, facilities, medical and nursing staff, and personnel into its own plan. Each individual hospital must make the best use of whatever that hospital has available. While all the plans so far presented in Canada have followed the basic pattern of an administrative, medical, and nursing section, there is need for over-all co-ordination among the various hospital groups. Disaster planning is not merely a question of having the three groups meeting and developing plans at departmental level. Successful planning calls for frequent consultation, the ironing out of difficulties, and the fitting

together of divergent views into one workable, practical plan for the hospital. Where more than one hospital exists in a community, it is essential also that the respective plans be co-ordinated.

The Toronto Western Hospital does not consider it possible to evacuate 80 per cent of patients. It is thought that the maximum number that can be evacuated from the 640-bed institution would be 160, which is 25 per cent. Other large metropolitan hospitals represented at the institute concurred with this viewpoint. The findings of the Toronto Western Hospital should be weighed carefully by all hospitals which have developed or are developing disaster plans. Perhaps we have been too prone to accept 80 per cent as a realistic figure; and it would appear that the evacuation of patients is an item which should be given very careful consideration in all disaster planning. It is easy to say that we are going to evacuate a high percentage of patients but, until an actual test has been carried out, it will remain a very theoretical matter. At some future exercise it is to be hoped it will be possible to test an evacuation plan.

While the development of a hospital disaster plan is not a simple matter, the Toronto meeting re-emphasized what has been said at previous institutes — that there is great benefit accruing to the hospital that prepares one. The benefits derived are a wider insight into the hospital's potential facilities and a clearer knowledge of the detailed structure of buildings and layout of departments. While this is not the primary objective in disaster planning, it is certainly a very useful and perhaps unexpected by-product to the planner. This greater insight into the institution makes hospital disaster planning doubly worthwhile.

More Medical Record Librarians Needed

THE NEED IN Canada for trained personnel to process medical records competently is still one of the major problems in hospital personnel supply. Most medium-sized and large hospitals are eager to obtain trained, and preferably registered, medical record librarians if one or more are not already on their staffs. The existence of a medical record department is essential to attain accreditation; not only for the division itself, but as an aid to the functioning of the over-all medical staff organization.

The seven Canadian hospital schools cannot enrol sufficient students to supply the number of qualified medical record librarians required and their graduates are usually employed long before the one-year course has been completed. The two-year extension course for training medical record librarians, sponsored by the Canadian Association of Medical Record Librarians and the Canadian Hospital Association provides a partial answer for those already employed in this field. To date, however, the number of acceptable applicants has not exceeded those who can be trained during a given year.

In addition to nurses who wish to retire from floor duty and responsible women who re-enter the world of employment, this is an interesting area of work for the student who is ready to be employed after four or five years of secondary school education. Recruitment of these students must usually be done locally. To obtain the co-operation of high school teachers (vocational guidance counsellors in particular) might be a worthwhile step. On the other hand, if you are aware of a likely student who displays an interest in the work of the medical record department and have no need for that person in your hospital, please inform your association. If the person is willing to locate elsewhere, that office may be able to match job seekers and career opportunities.

It is the aim of this association to have a qualified (and preferably registered) medical record librarian in every hospital in Canada where the desire for such an employee has been indicated. Since the supply is below demand, let us all co-operate in their training. This requires your assistance in two respects: the potential librarian must come not only from the large city, but from each community — your help is needed in finding them. Once found, they must be encouraged to enrol for training at a school or in the extension course. It is the individual hospital which must help in both finding and sponsoring medical record librarians; and it may be possible that the hospital will also have to subsidize them during their training. The hospital schools and the extension course for training medical record librarians exist in the hope of equalizing demand and supply. Both need your co-operation in discovering candidates in sufficient numbers. — *R.J.M.*

For Trustees Only

TRUSTEES are usually very busy people in their own sphere of activity and in the community. In fact it is usually because of proven interest in local affairs that one is asked to become a member of a hospital governing board.

Hospital policies cannot be handled always in the same manner as a somewhat equivalent problem would be settled in business. The place of the hospital in the community, with its need to provide ever-better care for patients regardless of their ability to pay, is in itself a consideration which is not found in the world of commerce. Then, the relationship of the medical staff to the hospital is not easily related to other fields of endeavour. Hence the trustee needs to be made aware of hospital functions, standards, and ethics, before he or she can be expected to make a satisfactory decision upon matters of small or great importance.

Being a person of many interests, however, the trustee cannot be expected to accept unreasonable demands upon his or her time in becoming familiar with hospital aims and activity. The wise administrator will provide accurate and easy methods of keeping the trustee informed. In addition to such aids as adequate notice of meetings and advance warning of agenda contents, news briefs or a house organ provide a valuable channel for information. Encouraging attendance at regional and provincial conventions, providing condensations of statistics and interesting articles, and a subscription to a hospital journal, are other methods of stimulating the interest of a trustee. Commencing with this issue we are including a page for trustees only. It is hoped that over the months this will prove of value in keeping busy trustees informed of what other trustees in Canada are thinking and doing regarding matters of mutual interest *(see page 49)*.

Unions Come to Hospitals

G. W. Reed,
Associate-Professor of Law,
University of Alberta,
Edmonton, Alta.

THE SUBJECT to be discussed here is not "Ought Unions to Come to Hospitals" but "Unions Come to Hospitals". It is true that in a few jurisdictions on this continent hospitals have been exempted from labour relations legislation with the result that, while unions are not prevented from trying to organize hospital employees, the hospitals so exempted are not bound by law to bargain collectively with the unions. This happened recently, for example, in the State of Utah and it is also the situation under the Taft-Hartley Act which deals with labour-management relations on the federal level in the United States.

It has not happened in Canada. In fact statistics supplied the writer by the Department of Labour in Ottawa indicate that some 21,000 hospital employees are presently affected by collective agreements in Canada. These are about equally divided between Quebec and Ontario on the one hand and the four western provinces on the other. Apart from a very small number of employees in New Brunswick, hospital employees in the Maritimes and Newfoundland have not as yet been unionized. Generally speaking, in the other provinces only the larger institutions are presently affected, but the indications are that many hospitals across the country are going to be faced with organizational drives in the near future.

The primary object of this article is to give an account of what happens when a union attempts to organize the employees of a hospital so that those in hospital management who have not yet faced a union drive will have some idea of what to expect and of how to prepare themselves. To this end the following topics will be discussed: (1) Why trade unions? (2) What happens when a trade union starts an organizational drive? (3) The impact of unions on hospitals.

Adapted from a paper delivered to the 10th Institute for Hospital Administrators and Trustees of Western Canada meeting in Edmonton, June, 1955.

For present purposes a union may be defined as an organization of employees formed for purposes that include the regulation of relations between employers and employees. Its primary purpose is the improvement and maintenance of wages, working conditions, and the general economic security of its members. It is important to note that maintenance of a position may be as strong a reason for a worker joining a union as the improvement of that position. Economic security can quickly disappear if an employee has to bargain with his employer on an individual basis and employees are more and more beginning to realize this. Hence the fact that the non-professional staff of a hospital may be looked after reasonably well at the moment is no guarantee that they will not respond to an organizational drive.

However, the economic motive is obvious. What might be termed the sociological reason is not quite so patent although of considerable importance. Stated briefly it amounts to this. Trade unionism reflects the need of every person to count as a human being. With the coming of the Industrial Revolution and the resulting separation of the new working class from the land, with increased mechanization and the ever-widening gap in employer-employee relationships, workers found that they counted for little; that they were nothing but small cogs in an extremely large and complex machine. As was pointed out in *The Canadian Hospital*, March, 1950, p. 42, whatever the faults of the system prevailing prior to the Industrial Revolution, the land at least gave to those who formed part of it whether as owner, leasee or worker, a sense of security. It formed the basis for their lives. The new system destroyed this and left nothing in its place except an impersonal, pecuniary interest. Trade unions were, in part, an attempt to fill the gap. Despite the improvement of the worker's status in the past 100 years it is submitted that the gap is still with us and sometimes consciously, often subconsciously, is one of the reasons why persons join unions.

The reader's reaction to this may well be: "while this may apply to the industrial worker it does not apply to the hospital employee because hospital work offers something which industry does not, that is, the opportunity to engage in a service of mercy and this opportunity for doing good gives to the hospital employee that root or interest lacking in industry".

To this there would appear to be at least two answers. In the first place although the argument may apply to professional and even technical personnel, it is questionable whether it is applicable to the lay staff, to janitors and dishwashers, to the people working in the office or the laundry. Secondly, even if this is not the case it will still be difficult for such persons to remain isolated from the movement if the locality in which they live and work is strongly unionized. This happened in San Francisco, a strong union centre, where the Hospital and Institutional Workers' Union, an affiliate of the International Building Service Employees' Union, was able to secure contracts with hospitals in that city in the early 1930's and, in 1941, negotiated an industry-wide agreement. But it was not until some years later that the unions were successful in their organizational drives in hospitals in surrounding communities, East Bay for example, because in those areas there was not at that time, a well organized labour movement.

Those responsible for the policy-making, management, and administration of hospitals are urged to give these matters some thought. Reflection may help them to realize that they cannot expect to be immune from a movement which, in addition to improving the economic status of workers has, in the words of the Twentieth Century Fund's *Study of Trends in Collective Bargaining*, endowed them with a new sense

of dignity, of status, of, in short, counting as human beings.

Unions Come to Hospitals

The next question to be considered is: what is likely to happen once a union starts organizing a hospital? The first thing to notice is that much that can or will happen is regulated by statute. The legislation in the provinces, while essentially the same in principle, differs in some details. What follows may be taken as generally applicable to all the provinces unless otherwise indicated. However, no attempt is made here to deal with the actual situation in each province because that would only serve to confuse the general issue. Those interested in a detailed picture should consult the relevant legislation in their respective provinces.

Organizational drive

The first step towards unionization is an organizational drive. This means that attempts will be made by representatives of the union or unions concerned to persuade employees to join the union or in some provinces, Alberta for example, if not to join then to elect the union as an agent for the purpose of bargaining on their behalf with the hospital. While the drive may be organized solely by a group of employees in the hospital, the chances are it will probably originate with representatives of a national or international union and this means that skilled organizers will likely direct or even actively participate in the campaign. It may be that two rival unions will be seeking to establish themselves in the one institution.

Whatever the situation, hospitals must realize that the law makes it an offence to interfere with the organizational drive. Employers or their representatives must not in any way seek to intimidate or persuade, threaten or suggest to employees that they must not or ought not join a union or any particular union. Nor may employers seek to find out who among their employees are interested in the union. A number of employers have discovered that it does not pay to sit in a car outside a building where an organizational meeting is scheduled to be held. Nor is it a good idea to fire employees known to be advocates of the union unless there is just cause apart from their union sympathies. This sort of activity on the part of an employer constitutes an unfair labour practice and may result in prosecution. The legislation gives the employee the right to join the union of his choice and to be represented by it and frowns severely upon persons interfering with the union and its drive.

On the other hand, unions and their representatives have no right to coerce or intimidate employees into joining a union. Nor have they the right without the consent of the employer to carry on an organizational campaign while employees are at work and this would seem to extend even to rest periods. These too, constitute unfair labour practices and are forbidden by law.

Certification

Once the union believes that it has a majority of the employees it is seeking to organize signed up as members of the union or at least in favour of the union acting as their bargaining agent, then it will apply to the Labour Relations Board of the Province (in Prince Edward Island to the Provincial Secretary) for a certificate constituting the union as the bargaining agent for the employees in the hospital. The Board's task is, among other things, to determine whether the majority of the employees are members of the union or have elected the union as their bargaining agent and, further, whether the group or unit of employees represented by the union is an appropriate one for purposes of collective bargaining. It may be, for example, that the proposed unit contains persons who are not entitled under the legislation to have a bargaining agent. Doctors and dentists fall into this class and so do persons employed in a confidential capacity.

The Board conducts investigations, may hold a hearing and may take a vote by way of secret ballot among the employees. The employer is always notified of an application for certification and always has the right to make such representations to the Board as he sees fit, either orally or by way of a written brief. It is useless, however, for the employer to take the stand that there is no place in hospitals for unions. They have the right to be there and it is not the Board's function to question the legislation.

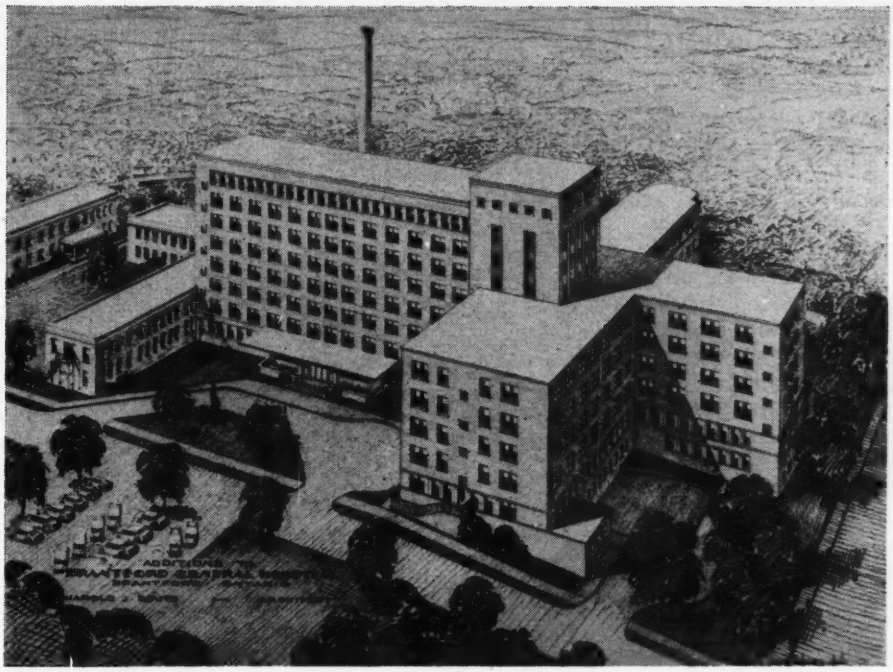
Often there will be a dispute as to who should be included in the bargaining unit. The employer may take the position that certain personnel included in the proposed unit are employed in a confidential or supervisory capacity. Nurses' aides or certified nursing assistants have caused some problems in this connection. They are excluded from the unit in Alberta but despite opposition by the hospitals have been included in Ontario. Technicians are usually excluded but were included in the unit certified for the McKellar General Hospital in Fort William, Ontario. A rather unusual case was the inclusion of nurses in the bargaining unit at the Vancouver General.

Another matter of concern to the employer is whether the union does in fact represent a majority of the employees. While this is a legitimate concern employers must not be carried away by their anxiety. It has already been pointed out that an employer is not entitled to sound out his employees on this matter. To do so constitutes an unfair labour practice and if it should appear to the Board that the employer has been engaging in such activities his case will be greatly weakened.

Of course there are many lawful ways in which in employer may learn of dissension among his employees. For instance some of them may of their own accord complain to him of intimidation by the union or of their desire not to be represented by the union. In these circumstances it is perfectly proper for the employer to raise the matter before the Board. Normally, however, the employer will have to depend on the investigation conducted by the Board and while it may seem unfair not to be given the details it must be remembered (1) that it is because of past experience with employers that the legislation has been drafted to exclude employer interference; and (2) that the Labour Boards are well aware of their responsibilities in these matters and so conduct a thorough investigation into the question of whether the union does in fact represent a majority.

Collective Bargaining

The certification of a local chapter of the union as a bargaining agent for a group of the employees in a hospital enables the union representatives to say: "Here is proof that we represent your employees. No other union can come along while we have this certificate and claim to bargain on behalf of your employees. We are the certified bargaining agent. You must bargain



Additions to Brantford General Hospital

Pictured above is the architect's sketch of additions to the Brantford General Hospital, Brantford, Ontario, which are expected to be completed in 1957. The institution will have a total of 515 beds, an increase of 131 over its present capacity. The first phase of the building program consisting of a power plant and laundry, was completed in January of last year. The hospital is being constructed on the same site as the old one. The two-storey structures shown are part of the existing hospital, The five-storey wings at the right are new additions while the eight-storey central structure will be added when the present main building is removed. The architect is Harold Smith, Toronto.

with us." And that is so. Under the law the hospital must now bargain *in good faith* with the bargaining agent of the employees with a view to entering into a collective agreement with that agent as the representative of all the employees in the bargaining unit. And this agreement, if entered into, will be binding on all the employees in the unit whether members of the union or not. As has been pointed out, however, the union does represent at least a majority in the unit.

Conciliation and Arbitration

It is during the collective bargaining that trouble may come. It need not but it may. Suppose the parties are unable to agree and an agreement therefore, cannot be concluded. This does not mean that the union can immediately call a strike. If deadlock is reached the process of conciliation will normally come into play either because one of the parties to the dispute requests it or because the government decides to intervene. A conciliator will be named. He is usually an employee of the Department of Labour and his task is to try to effect a settlement or compromise between the parties.

If he is unsuccessful then in many cases a conciliation board (in Alberta called an arbitration board) will be set up to try and bring the parties together*. Usually this board will consist of a nominee of each of the parties and a chairman chosen by the two nominees or, if they are unable to agree, by the government. If the board fails in its task legal strike action may then be taken providing the union has complied with the various provincial requirements with respect to strike votes. Of course if no conciliation board is set up, strike action may follow the report of the government conciliator. Strikes will be dealt with more fully *infra.*

The Agreement

Let us assume the parties are able to settle their differences by one of the above processes. A document, called a collective agreement, will then be drawn up incorporating the terms of settlement. The drafting of this agreement requires great care, for it must be borne in mind that this document will govern the relations of the parties during the time the agreement is in operation.

It is also important to note that the law provides that certain things must be incorporated into the agreement. Thus, for example, it must be for at least a year's duration. The parties may agree on a longer term but the agreement must, by law, be for at least one year. Again, the agreement must contain a provision for the peaceful settlement of disputes arising out of its operation. In other words, during the term of the agreement there can be no strikes or lockouts. If it does not contain such a clause, the Labour Board is authorized to write one in on the request of either of the parties. The one exception to this is in Sask-

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**In Quebec and Prince Edward Island the situation is a little different but the principle that strike action cannot be taken until attempts have been made to bring the parties together is the same.*

In-service education for the

Department of Nursing

Margaret M. Street, B.A., R.N.,
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AN EFFECTIVE program of staff education ranks high among the objectives of a dynamic hospital administration. Management should recognize that the quality of service rendered to the patient is dependent upon the contribution of the individual staff member and correlation of the effort of all personnel. It is important, therefore, that each member of the hospital personnel be given the opportunity to grow and develop in service, to keep abreast of current trends in his field, to be aware of the aims of the institution, to recognize his role in helping to realize these aims, and to appreciate the contributions of other employees and the value of team-work in the total organization.

The major purpose of staff education is to improve the quality of service by assisting all members of the staff to develop their potentialities to the fullest possible extent and to co-operate most effectively with others in the organization. To the employee, the program affords a valuable opportunity to improve and advance in his chosen work. As his capabilities increase, so too will his satisfaction in his job and the satisfaction of the employer with his achievement.

Essential Conditions

Although it is difficult to specify a formula for a successful staff education program within a hospital, certain general principles may be applied in its development:

1. The program should be flexible and adapted to the changing needs of the service situation.
2. Staff motivation must be keen, if the program is to be effective.

Some of the ways and means to ensure interest on the part of personnel are:

(a) Staff participation in planning, publicizing, and administering the program.

(b) Timeliness of topics in relation to need felt by personnel.

(c) Favourable conditions for effective learning, such as a suitable time and place for sessions, stabilization of the service to permit staff members to attend, provision of adequate facilities (e.g., reference materials, blackboards, films), and general excellence of presentation of topics.

It is fairly generally recognized that staff education to improve the service should be scheduled in on-duty time; however, since the employee also benefits, it may be possible to plan sessions partly in hospital time and partly in off-duty time.

(d) Opportunities for staff participation during program sessions, through discussion groups, demonstrations by members of the staff, et cetera.

(e) Affording opportunities for employees to apply what they have learned, to exercise creativeness, to experiment with new methods, and to carry out studies and research on return to the work situation.

(f) Recognition of the increased capabilities of individual staff members, through additional responsibilities, promotion, and salary increases.

An essential condition for success is that the impetus for carrying forward the program of staff education should come from the employee group.

Scope

The scope of the program may be organization-wide (*e.g.*, instruction regarding fire drill or safety measures) or may be confined to a department. In a large hospital, the latter is the channel most frequently used for staff education. One staff member in the department should be charged with the responsibility of giving leadership to the program, assisting with its development, acting as consultant to planning committees, helping to secure materials and facilities for its implementation, and co-ordinating educational activities within and beyond the department.

A brief report on recent developments in the staff education program in the department of nursing of our hospital may be of interest.

This institution, is a 625-bed hospital, opened in March, 1953. A feature of the expanded Calgary General was the establishment of certain departments and services which either had not existed at all in the old hospital or had not been present in segregated form. A distinct challenge was thrust upon the department of nursing to adjust to the demands of the larger organization and to give the quantity and the quality of service required by both general and specialized clinical areas.

Preparation of Faculty

The first requisite was recognized to be the preparation of nursing personnel for new specialties in the institution. Carefully selected and interested members of the nursing personnel were sent to other centres for guided observation, study and experience in such areas of nursing as: neurosurgery, urology, obstetrics, central supply, emergency service, poliomyelitis, orthopaedic and rehabilitation nursing, clinical teaching in operating-room, team organization, oxygen therapy, and so on. The length of time taken by these study tours and courses varied from ten days to four months. Financial assistance for staff members was secured from grants made by the Alumnae Association of the Calgary General Hospital, women's service clubs of the community, professional training grants, and the Canadian Legion Poliomyelitis Fund. Several of the nurses willingly defrayed a part of their expenses. In many instances the nurse's salary was paid in full while she was away. As staff members returned from tours and courses, each one shared the highlights of her experience with the whole group. At the same time, the returning member was afforded the utmost co-operation and assistance for implementation of newer nursing methods and for the instruction of other personnel. In a number of instances these nurses were drawn into the school of nursing program where they have been making a fine contribution to student education.

University Preparation

Other members of the staff interested in further preparation through university courses in teaching and supervision were encouraged to complete their certificate or degree requirements. This promised a solid nucleus of well-qualified personnel for the present and the future, to carry key responsibilities in both the nursing service and the school of nursing. Although the absence of valued staff members for a year or two of uni-

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This is the third of a series of articles on in-service education programs at the Calgary General Hospital. (See "The Canadian Hospital", June, pp. 38-39.)

versity training represents a temporary sacrifice, the ultimate return to the organization is ample recompense; and somehow it always sseems possible to make the necessary adjustments. It should be added, with appreciation, that federal-provincial professional training grants have been instrumental in making it possible for many staff nurses to secure university courses.

In-Service Activity

In September 1953 a clinicial co-ordinator was appointed whose responsibility was to direct and co-ordinate staff education in the department of nursing.

One of the first assignments of the clinical co-ordinator was to conduct an in-service course in ward administration for head nurses. At the outset it was recognized that this program could not replace a university course in teaching and supervision. It was designed to serve a real need of which the head nurses were conscious. It would serve also to bridge the gap until these head nurses might arrange to get away for university study. The program, in the planning of which the head nurses shared, was scheduled once weekly for a two-hour period. It extended from September to early May of the following year—a total of fifty-four hours. Speakers included the chairman of the Board of Governors, the hospital administrator, the director of nursing, the business manager, the associate director of nursing education, and the clinical co-ordinator. Much of the work was done through discussion groups and projects. One of the most useful projects was the development of a ward inventory for the new hospital. Another was joint planning with clinical instructors of objectives, methods, and scope of student nurse programs in various clinical areas, and the presentation of these, in panel form, to the whole group of head nurses. This project gave a decided impetus to the clinical teaching program and served as well to acquaint head nurses with the content of teaching programs in other areas.

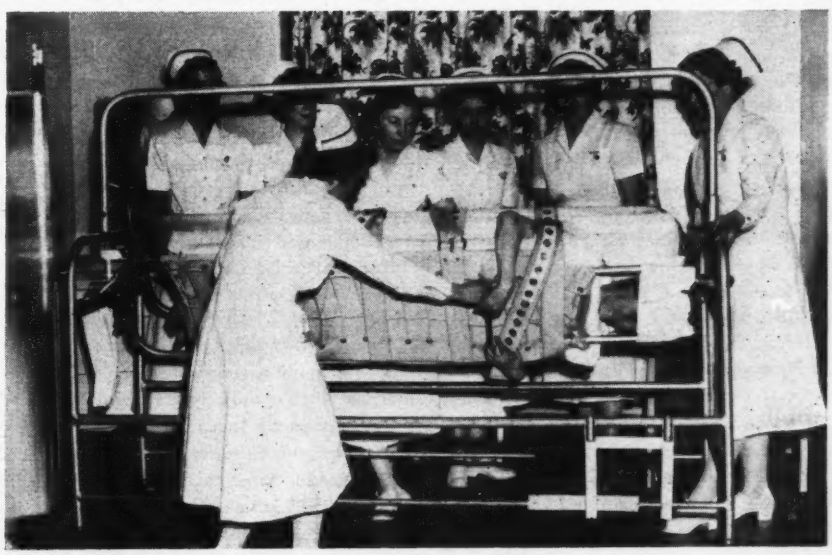
Encore

As the course in ward administration drew to a close with the coming on of the vacation season it was generally agreed that the next step should be a program in evaluation methods and techniques, which, it was felt, should be participated in jointly by head nurses, supervisors, and the faculty of the school of nursing. At the present time, this course is going on under the leadership of the associate director of nursing education and the administrative assistant, nursing service.

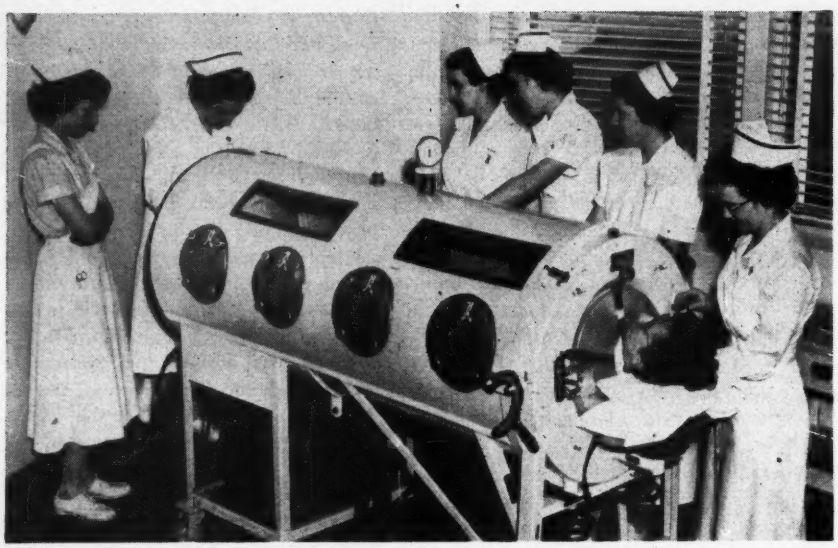
Orientation to Nursing Service

The need of an effective orientation program for nursing personnel was the next area of interest. The development and administration of this program was made a responsibility of one of the supervisory assistants in the nursing office. Although it is still in its early stages, the new plan for induction of employees into their work is much appreciated both by incoming personnel and by the wards and departments receiving them. The orientation for graduate nurses covers a four-week period, and includes the following aspects: Personnel policies, tour of the hospital and of the ward or department to which assigned; review of health services available; organizational chart of the department of nursing and of the hospital; philosophy of nursing care in this institution; methods of staffing; methods of evaluation of personnel; demonstrations of equipment and procedures used in this hospital; routines and policies of the hospital and the ward to which assigned; observation in the central supply room; the team plan; the educational program of the school of nursing, including the rotation of students through the clinical services; responsibilities of general staff nurses toward student nurses; routines of various departments (*e.g.*, x-ray, physiotheraphy, laboratory) and nursing responsibilities in relation to these; records, requisitions, and reports; and the Staff Nurses' Association. The supervisory assistant calls upon the following group to assist with the induction: the director of nursing; the associate director of nursing (clinical co-ordinator); the administrative assistant, nursing service; the associate diretcor of nursing education; the health nurse; nursing arts instructors; and head nurses and clinical instructors.

A somewhat simpler orientation program is conducted for certified nursing aides. Job-in-training courses are given to new orderlies by the senior nursing arts instructor. Still to be de-



Miss P. Boch, Head Nurse, demonstrates the use of a Stryker frame to a group of graduates and senior student nurses.



Instructions on the manual operation of an iron lung are being given by Miss D. Barker (second from the left), Clinicial Instructor, to the staff on the isolation ward at the Calgary General Hospital.

veloped is an induction program for ward clerks, whose work is quite complex and is filling such a great need in the busy ward situations.

Education in Professional Care

In the area of bedside nursing care, several major projects have been completed. These have been of general nature, open to all nursing personnel and of more specific purpose for specialized clinical areas.

As a rule, one large staff program is scheduled each year to include all nursing personnel. This is conducted under the auspices of the educational committee of the Staff Nurses' Association. In the fall of 1953, the main program was on poliomyelitis nursing. Evening sessions extended over several weeks and were opened to nurses from other hospitals, health agencies, private duty, and from the community at large. The course included lectures, panel discussions, films, demonstrations, and practice periods for participants desiring these. Assisting in the course were doctors, interns, staff nurses, physiotherapists, a public health nurse, a social worker, an occupational therapist, student nurses, orderlies, nursing aides, and a former patient. All who contributed to the program felt that they had learned a great deal about this timely subject.

Beginning in the Spring of 1954, and on into the Fall, the next major topic for staff study was "The Care of the Patient with Paralysis." This began as a medical-nursing study of ways and means to improve the care of the hemiplegic patient but it was soon apparent that the same general principles applied in the care of other paralytic patients, *e.g.*, those with spinal cord injuries, poliomyelitis, *et cetera*, and the course was broadened accordingly. Sessions included demonstrations, planned and carried through by head nurses and ward nursing personnel and students, showing: care of the patient with hemiplegia during the acute and the convalescent phases; and care of a patient with a fractured cervical vertebra, spinal cord injury and quadraplegia, from time of admission by ambulance stretcher to post-operative care on a Stryker frame. Teamwork was beautifully illustrated through these demonstrations, together with newer methods of care and new types of equipment. The physiotherapy department played an important role as did representatives of the social service and the occupational therapy departments of the Colonel Belcher (D.V.A.) Hospital, and a speech therapist from the Cerebral Palsy Unit.

Training in Smaller Clinical Areas

We are beginning to realize the value of in-service education developed within a ward or clinical service. Such programs can be administered as the need is felt by the staff group and can be productive of great improvement in the quality of patient care in the area. Recently, in this hospital, an assistant head nurse was sent away to take a course in poliomyelitis, orthopaedic and rehabilitation nursing. Returning to the orthopaedic ward, she successfully implemented courses in that division for graduate nurses, nursing aides and orderlies, and has followed through with continuing supervision at the bedside. She is involved actively in the teaching and supervision of student nurses. The result has been a marked improvement in the quality of patient care plus a stronger student program in orthopaedic nursing.

In this, as in other parts of the staff education program, the group concerned has helped in the planning and administration of the courses. They were consulted regarding the most suitable time for sessions. Their preferences for topics were elicited during a discussion period in a social setting, an informal tea having been arranged for that purpose. Staff members, on request, completed a questionnaire which proved to be of considerable help in planning the details of the graduate nurse course.

Another recent development in the staff education program was a short course arranged by the director of nursing and the business manager on the subject of oxygen service. A company which supplies oxygen to our hospital kindly consented to conduct the course, which was attended by staff representatives of this and other hospitals in southern Alberta.

A course for the development of team leaders is seen as an urgent need in this institution, and will probably be given priority in program planning for the immediate future.

Results

Valuable means of promoting the growth of personnel in service, in addition to the methods outlined above, include the use of democratic methods of administration whereby staff mem-

(Concluded on page 76)

From an address to the
B.C. Hospitals' Association
October, 1955

"ready co-operation essential . . ."

The Hon. Eric Martin,
Minister of Health and Welfare,
Victoria, B.C.

WHENEVER I meet the general public, and that is quite frequently, people always press home two important points: (1) they are quite satisfied that their hospitals are in good hands, that a high level of service prevails, and that everything is being done to ensure a satisfactory level of hospital management; and (2) they are most anxious to ask that all avenues be explored in order to keep stabilized the inflationary tendencies of over-all hospital costs.

They say, in effect, that we have a very good hospital arrangement. Good management plus a good plan. The major problem lies only with the manner in which costs may rise, and the extent of such a rise.

In 1954, I pointed out how absolutely necessary it was for us to keep hospital costs within the limits of the public's purse strings. I made comparisons with other government departments, and showed that the cost of operating acute general hospitals accounts for more public funds than any other single department. Since then, due primarily to the introduction of the new school formula, the figures and percentages have changed somewhat, but the main fact remains unchanged. Hospital costs account for just about the largest single slice of provincial appropriations.

This reflects society's desire for adequate and essential hospital facilities and is based upon the fundamental concept that good health is society's most valuable resource. I agree most heartily with this concept, and I feel sure that there would never be any argument with regard to the importance of providing and maintaining a high standard of hospital service.

There is no doubt that we in this province enjoy one of the finest standards of care available anywhere on this continent. As I mentioned last year, we have more hospital beds, more employees per hundred patients, and higher wage scales than elsewhere in Canada. The inevitable result of this is that our costs are higher than those met generally throughout the rest of the provinces.

There is no doubt whatsoever that hospital costs have increased tremendously since 1948. For example, the total cost of hospital administration in 1948 was $16,000,000. This year it will be roughly $37,000,000—an increase of about 125%. Let's look at this a bit more closely—

Salaries and wages are up	— 154%
Drugs, medical and surgical supplies are up	— 90%
Dietary costs are up	— 48%
All other costs are up	— 66%

Even when an allowance is made for new beds, which have increased about 32%, it is obvious that hospital costs have accelerated at a very dangerous pace; and it is gravely important that the hospitals of this province realize the necessity for constant vigilance in this regard.

Hospital services are certainly very essential but one must also consider at all times the over-all provincial economy; and hospital costs must always be considered in relation to other provincial expenditures.

A government is responsible to the people for the successful administration of all government departments, all government services, all crown corporations, and all government commissions. The government's job is to govern, and, by so doing, keep all essential services in the fore, so that they all might progress in accordance with the public's desires and within the limitations imposed by the economic conditions of the province, and the prosperity of the people.

If any particular service is furthered at the expense of some other vital service, then a great wrong is being done. At all times, the government must keep all its services in a fine balance with economic conditions and all other essential services.

That is why at your last convention I asked you to continue in your efforts to keep down the costs of hospital care; and I stressed this need because I knew that the provincial economy could not stand a continual increase of the nature experienced in hospital affairs over the past six years.

As you are aware, the sales tax was increased 2% to cover the premium levy of qualified residents, and the resulting 5% social services tax is now used to pay for all social services of the provincial government such as social allowances, bonuses to old age security recipients, old age assistance, mothers' allowances, blind allowances, disabled persons allowances, and a host of other such services.

But what is not so generally known is that, right at the start of the new plan in 1953, the minister of finance announced in the legislature that funds derived from the proceeds of the 2% additional tax would be insufficient to cover fully payments to hospitals on behalf of beneficiaries. After application of funds received from municipal and provincial per diem grants, the balance of funds required to finance the B.C. Hospital Insurance Service are provided from the general revenue of the province.

Fiscal Basis

One of the difficult aspects of the financial structure is that the operations of your hospitals are based on a calendar year, while the government operates on a fiscal basis. Of course, I understand the reasons for this difference and feel quite sympathetic towards them. However, such understanding does nothing to alleviate the problems which arise from this difference and problems which cause difficulty to the smooth and harmonious functioning of our relationships. For example, you must prepare your budgets and submit them to the service on a time basis which cannot possibly tie in with the appropriation of funds by the legislature.

And this is a point which I would

stress—the funds by which the service operates are provided not by the service, not by me, but by the Legislative Assembly of British Columbia. Until they have provided the money for the future fiscal year's operations, we have no knowledge of what amount will be available.

This resolves into a problem arising out of the differences in our accounting procedures, since you work on a calendar year and the government on a fiscal basis. You submit your budgets but there is a delay of several months before it is determined what your per diem rate will be. This will never be different as long as hospitals operate on a calendar year basis.

However, I want to stress this very important fact. The funds for the operation of the B.C. Hospital Insurance Service are appropriated by the Legislative Assembly of British Columbia. When they have voted the amount which will be apportioned for the forthcoming year, there are no other sources of funds from which the service can draw throughout the rest of the year. The cloth has been cut, and all resulting activities must necessarily be tailored to fit within the amount provided.

A very misleading statement made recently was that the B.C.H.I.S. was without the status of a deputy minister and the inference was that it was only a secondary responsibility of the Health Branch. Nothing could be further from the truth—Donald M. Cox, Commissioner of B.C.H.I.S., as you will all agree, is one of the foremost authorities on hospital management on this continent, enjoys the complete confidence of the government, and has the status of deputy minister. In addition he answers directly to me for the operation of this most important department. We are very fortunate in having this calibre of man at the helm of our Hospital Insurance Service. Matters pertaining to hospital insurance have occupied more of my own time than either the Health Branch or the Social Welfare Branch. To infer indifference to this department is a great wrong, besides being factually incorrect.

Policy and Administration

At this point, I would like to mention a most important distinction between policy and administration. It is essential that we all clearly understand that only the government sets policy. The Legislative Assembly through debate and vote sets the amount of funds available for the year to come, the government then sets the policy concerning certain aspects of these funds—that is, the specific way they will be administered—while the service puts into administrative practice the policy which is formulated and enunciated by the government. It was with regret that I became aware of the misunderstanding many had on this point. Some thought that the service, or more specifically one of its senior officers, decided what was policy. This thought is completely erroneous. Policy is set only by the government, while funds are provided only by the legislature.

When the legislature has established the fiscal provisions for the coming year, the government then sets the policy. The officers of the B.C. Hospital Insurance Service are then directed by me to translate this policy into administrative practice.

Co-operation Essential

That is the specific line of authority, which must always be kept clear and distinct. However, a most important ingredient in the successful operation of any government service is the full and ready co-operation of all groups who move in conjunction with the service.

The co-operation of the hospital boards of management and administrators is essential in bringing forth the services demanded by the people of this province. The co-operation of the community is also necessary as is that of physicians.

The government has asked for the co-operation of the doctors on different occasions because we are fully cognizant of the important part they play in the provision of hospital services. The support of the medical profession is perhaps the most important single ingredient in the success of any hospital insurance plan. Rate of admission and length of stay are two extremely important aspects of hospital management which bear heavily upon costs. For this reason the government asked the physicians to conduct a survey into these two factors in the hope that recommendations could be forthcoming which would be advantageous to hospital insurance and consequently to the people of this province.

It is absolutely essential that the people within each community realize their responsibilities and shoulder their obligations in this regard; it is also essential that the workers within the hospital realize that the standard of their employment must remain within reasonable bounds. The management of each hospital must be cognizant of their responsibilities, as must officials of the Hospital Insurance Service; and the doctors within the community must realize their very important position in the over-all scheme of things. Between all groups must be co-operation. Knowledge, sympathetic understanding, and a desire to work for the common good rather than personal ambitions must be the motivating force.

Length of Stay

One might well ask why the government is so concerned about length of stay in the hospitals. Let me point out the trend of hospitalization in this province. In 1949, the number of patient days per 1,000 of population was 1,528 which incidentally was considerably higher than the national average. By 1952 this had remained fairly constant but in 1953 it rose sharply to 1,638 and by 1954 had jumped to 1,786, an increase of roughly 14% in two years.

If we look deeper into this problem, we see that those communities which have recorded a substantial increase in the number of hospital beds saw a resulting rise in length of stay. For example, in community A, length of stay increased from 9.3 to 10.3 when new hospital facilities became available. Other areas show increases as high as 20% in length of stay. Of course, these increases have a terrific impact on costs. The question is, what is bringing these increases about? There seem to be indications that in those areas where beds were built for future use they are being utilized now with a greater length of stay. There are trends which point to utilization of acute beds by chronic patients.

There are many questions arising out of the increasing length of stay, and it was for this reason we asked the doctors of this province to look into the over-all situation of admissions and length of stay in the hope that something would evolve which would benefit the plan.

You have all heard about the survey, investigating this very point, which

(Concluded on page 78)

From the presidential address to the B.C. Hospitals' Association

"an untenable position . . ."

Harvey E. Taylor,
Port Alberni, B.C.

THE PAST YEAR has been an eventful one in the history of our hospitals and association. The unprecedented action of the Government of British Columbia, through the Minister of Health and Welfare and the Hospital Insurance Service, in notifying all hospitals, by means of the now famous Circular 55-7, that "any increase in wages and salaries over and above the 1954 approved level will become the responsibility of the hospital board concerned", came as an unexpected blow to all hospital boards. We, as board members and executives of hospitals, realize that hospitalization must be provided at the lowest possible cost. We also realize that lives are much more important than dollars. Therefore, as custodians of one health service in this progressive province, we must consider the welfare of our patients, regardless of the "hold the line" policy.

Approximately 70% of all hospital costs are salaries and wages. Hospitals can oppose granting wage increases but only for a limited time. Every increase granted to industrial and other workers will eventually increase hospital costs through higher wages. We and the government who allot the funds for hospital insurance service will have no alternative but to accept increases brought about by economic pressures.

As I prepare this report the Canadian Pacific Railway employees on the coastal steamships have just received a substantial wage increase. The employees of The Union Steamships had an extended strike this summer and thereby gained pay increases. The I.W.A. (International Woodworkers of America) was granted wage increases and fringe benefits for 1955 and 1956. These trends and influences cannot be resisted indefinitely. The B.C. Hospital Insurance Service and the Provincial Government must also realize this. The hospital boards are in the untenable position of being unable to grant wage increases, even after conciliation and arbitration, unless they know the funds will be made available from which such increases may be paid.

The major source of hospital revenue is from the provincial government. It is for this reason that your executive has recommended that all wage contracts for 1956 shall include a clause making them subject to approval by the Hospital Insurance Service before they become effective. This has been termed "farcical" in certain quarters and apparently is not endorsed by all our members. However, your executive feels that there is no alternative. The hospitals are unable to increase income from other sources to meet the higher costs.

We realize that the government has a duty to the taxpayers to operate all its departments, of which hospitals are one, as economically as possible. We also realize that there are just so many dollars available from the taxpayers with which to operate government services. The Hospital Insurance Service and indirectly the hospitals, are allotted in the annual estimates a certain amount within which they must try to operate.

It would be helpful if hospital boards were advised of their approved budgets by January first to allow for twelve months reduction in costs, if any are found possible. They, in turn, should submit their estimates on time. The delay in submitting estimates is usually because of uncompleted wage negotiations. Possibly some action should be taken to assure the completion of negotiations by November 30th of each year, as required in the Hospital Insurance Act. However, to my knowledge, there is no means of enforcing this regulation.

Hospital insurance is a costly service; but we need not be too impressed by the quoting of lump sum comparative costs for 1952 and 1955. To compare such costs, we should know the increase in hospital beds, increases in total patient days, the average stay, the hours of work, and the cost per capita. We should also know the amount that is being received through the additional 2% sales tax and how much the general revenue is adding to the 2% tax revenue for hospital insurance costs. The 2% sales tax increase was not specifically earmarked for hospital insurance but was added to the 3% tax when premium collections were discontinued. To all intents and purposes this portion is for hospital insurance. Unfortunately, the public has forgotten that and people refer to the 5% sales tax as the hospital tax. Hospital costs will continue to rise so long as our economy continues to expand. We must do our best to operate economically and maintain services, not being unmindful of the necessity to expand services as the demand materializes.

The Hospital Insurance Service was recently queried on this matter of expansion of services; and the reply received was to the effect "that the hospitals would have to save the required funds from present expenses in order to improve and expand services". How can this be done, when they, the hospitals, are not permitted to retain savings, if any, except for the current year?

Greater Incentive for Personnel

There are several matters that bear mentioning at this time. One of these is a problem of the supply of, and the remuneration paid to, those willing to assume responsibility in our hospitals. The tendency of a large percentage of our professional and service staffs is to decline supervisory and executive positions. They are content to do a good job for eight hours a day but there is little incentive, in the small additional remuneration they may receive, for them to take on added responsibilities. There are few hospitals that have not experienced difficulty lately in securing a properly qualified and conscientious administrator, superintendent of nurses, operating room supervisor, ward supervisor, accountant, dietitian, or housekeeper. Greater incentive must be offered hospital personnel as encouragement to assume responsibilities. Perhaps the perspective has been unbalanced by making com-

From an address presented at the British Columbia Hospitals' Association convention, Vancouver, October, 1955.

parisons with other institutions instead of considering each situation on its own merit.

The last extensive amendment to our constitution and by-laws took place in 1950. It is time to review them thoroughly again. I recommend to the incoming executive that a special committee be appointed for this purpose and that they be requested to have any suggestions ready for discussion and action at the association meeting in June, 1956.

Effect on Trustees

I am concerned about the present method of freezing budgets and the constant accumulation of hospital deficits. If this trend continues, it may result in a loss of interest in hospital affairs by public-spirited citizens and the consequent refusal of these persons to act on hospital boards of management. There has always been limited appreciation for these community-minded persons who can only look upon their work on hospital boards as a service to humanity. The time may be rapidly approaching when these persons will consider their efforts wasted and refuse to act as hospital directors.

National hospital insurance would now appear to be under more serious consideration by the federal government than at any time in the past. The recent requests from Ottawa to the Premier of Ontario for his views on health insurance, the submission of a brief by our own Canadian Hospital Association, and the recent statement by the Canadian Medical Association on health insurance, would all indicate an active interest by the Government of Canada. Considerable discussion on the subject has already taken place at the Federal-Provincial Conference. Because of this interest in national health insurance it is imperative that we in the hospital field, through our provincial and national associations, watch developments closely.

Abuse of the caption

"For Routine Examination"

O. C. MacIntosh, M.D.
Director of Laboratories,
St. Martha's Hospital,
Antigonish, N.S.

THE ALREADY high and ever-increasing cost of hospitalization, in one respect at least, can be compared with the weather in that "everyone talks about it, but no one does much about it". It may be that rock bottom economy, as far as the operational costs of hospitals are concerned, has been achieved or closely approached in many institutions; but it is the writer's contention that, in so far as laboratory diagnosis is concerned, a critical consideration of at least one of its facets will reveal that some of the patients' money is being wasted. Value is not being received by the patient for the money spent on many so-called "routine" examinations.

The responsibility for this situation and its continuance cannot be laid at the feet of the humble patient; it must be born jointly by the medical profession and hospital administration.

The word "routine" used in connection with hospital laboratory practice has, through common usage, come to have two implications. In one instance, it means that the examination in question is performed on all patients or on certain specific classes or types of patients admitted to, or under treatment in, an institution. In the second instance, it means that the examination of a certain specimen submitted to the laboratory shall be considered to include a number of specific tests that need not be individually mentioned on the requisition except by the connotation of the word "routine".

Abuse of this word "routine" in our hospitals can lead to a tremendously over-burdened laboratory staff and to an unnecessary financial burden on hospital patients. Some aspects of the abuse of the word in the first instance of its meaning have been dealt with elsewhere.* The present communication † will deal with various aspects of its abuse in the latter instance.

The use of the caption "Specimen for Routine Examination" has a definite value and a definite place in the diagnostic work of every hospital. We cannot disagree with the practice of sending such a common specimen as an initial urine specimen to the laboratory with a request for "routine" examination. To request the medical attendant to state specifically what tests he would like performed on each urine specimen would be unnecessary and impractical.

In the field of bacteriology, the caption "Routine Culture" has also obtained through common usage a specific meaning and a distinct value. It is understood by most to indicate that the specimen is to be examined for the commoner easily cultivated organisms such as the staphylococcus, streptococcus, pneumococcus, et cetera. Obviously, we cannot expect these organisms to be enumerated on each requisition. As has been stated previously, with these and a distinctly limited number of other tests, the use of the word "routine" is not only admissable but advisable.

On the other hand, the caption is inadvisable and wasteful of time and money if it is attached to requests for the examination of all sorts and types of specimens referred to the hospital laboratory. What laboratory director or, indeed, laboratory technician has not seen urines sent to the laboratory "for routine examination" daily for weeks and even months when it was obvious that the patient was not suffering from diabetes and an estimation of the specific gravity, the protein and cellular content was all that was

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Effect on Laboratory Staff

Not only is the effect of this practice on the patient's bill of importance but so also is its effect on the "professional conscience" of the technical laboratory staff. Even the most dedicated technician cannot continue to produce accurate results when she knows full well that all these results are not being carefully appraised by the clinician. The demoralizing effects of the practice eventually infiltrate into all phases of laboratory work with a resultant lowering of standards of accuracy.

The watchful laboratory director can and does protect his staff from such impositions but the majority of our Canadian hospitals are not large enough to justify the employment of such personnel and the unfortunate laboratory technician is in no position to assert herself in this phase of her work. For the use of the "routine" possesses many advantages to two types of practitioners who, unfortunately, are found in many hospitals. One of these is the fellow who never has the time to write out specifically what he wishes to have done and the other fellow is the one who does not have sufficient knowledge of laboratory procedure to know what he wants done.

These individuals commonly submit all classes and varieties of specimens "for routine examination". By doing so, they unjustly protect themselves against any recriminations for, on the surface at least, they can't go wrong. In this respect, if any possible test on the specimen submitted in this manner is omitted by the laboratory and later is found to be required, they have reserved for themselves the right to return to the laboratory and belabour the laboratory staff for their omission. If the technician, on the other hand, in order to forestall such an occurrence, anticipated from previous experience, stays after hours doing all possible examinations on the specimen, they are quite prepared to note the results that are clinically significant and glance at the remainder in passing.

Many a young laboratory technician has met her "Waterloo" with a member of the medical staff on this very same point — the meaning of the word "routine". For what is routine examination of any specimen? Has there been any international or national commission of "Grey Beards" to pore over the problem and finally decide what the word "routine" shall signify for each of the varied specimens sent daily to a diagnostic laboratory? If such a momentous undertaking has been successfully completed, the results have not been given the publicity they deserve. I do not believe it is possible for such a group to agree on the problem and even if this were possible, local conditions render such a solution impractical in the majority of cases.

The "routine" system was, at least theoretically, workable when the possible elements of each routine examination were limited; but due to the enormous strides in laboratory technology, keeping pace with equally enormous strides in scientific medicine, the number of tests that can now be applied to any individual specimen is, theoretically at least, infinite and, practically, tremendous.

Case-finding

The argument may be raised that in a certain percentage of cases some of the tests may reveal a disease condition not even suspected. This statement is, of course, perfectly true but the answer to it is contained in the question: In what percentage of cases does this occur? In other words, is the time and expense involved justified by the percentage of positive results obtained? Apply this criterion in any laboratory where the practice of the medical staff is to call for innumerable routine examinations to be performed on a large proportion of the specimens submitted and even the most elementary system of cost analysis combined with medical common sense will show that a large proportion of the effort and expense, from a practical standpoint, is being wasted.

In this respect, sometime, somehow, somewhere, hospital, medical and public health authorities must be prepared to come to grips with the problem of the responsibility of the hospital in the so-called "case-finding field". That hospitals have a responsibility to their patients is true; but if hospital and medical authorities refuse to recognize the "law of diminishing returns" as applied to innumerable case-finding investigative procedures, whether supplied at hospital or patient cost, the result will ultimately be, on one hand, a bankrupt hospital or, on the other, a bankrupt patient. It is the author's personal opinion, which it is realized is not shared by many others, that extensive case-finding programs are not a hospital responsibility and should only be undertaken by hospitals on a supervised research project basis, preferably financed by a charitable foundation or government research grants. At any rate, I doubt whether anyone can justify the present practice of continuing laboratory procedures with very limited case-finding value, for this purpose, and having the patient bear the costs.

The specimen-for-routine-examination thinking and practice is encouraged in a hospital by retention of charge schedules which list the "routine" examination of a specimen at the same rate as one or more of its components; or specify a flat rate for a routine examination such as "blood chemistry" not greatly in excess of the charge made for one or two of the components. Laboratory charges as all other hospital charges should reflect costs, as much as possible, if hospitals are ever to find their way out of the morass of deficit financing. Each laboratory examination should be charged for at a rate proportionate to the time and expense involved in its performance and this fact should be

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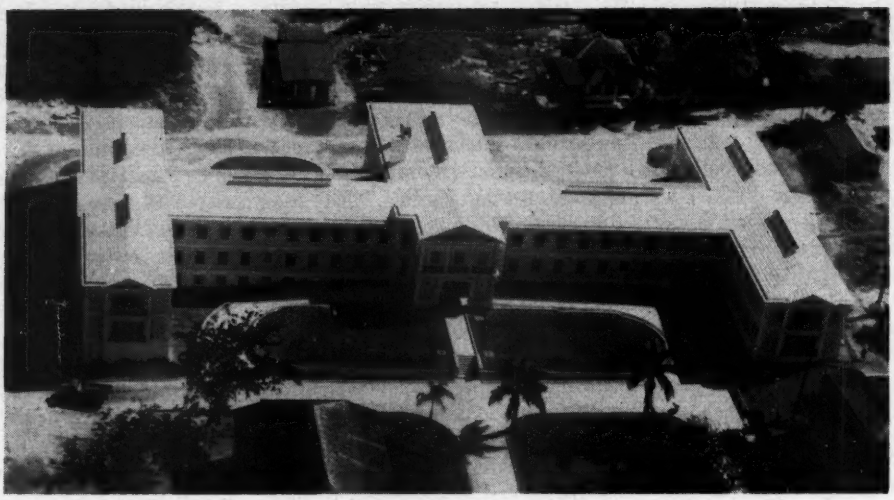

The Princess Margaret Hospital

contributes to health services in the Bahamas

AS MANY visitors from Canada can testify, the climate in the Bahamas is conducive to good health. Our winter months, when northerners flee the cold, are for the islanders a busy season. However, because there are few extremes in temperature and consistently cool breezes at night, the tourist season is rapidly becoming an all-year one. The general pace of living is slow in comparison with the rat-race we have come to know; and that in itself is of great benefit to the visitor who requires rest and to some extent must be the reason for general good health among the permanent population.

The Medical and Public Health Service is administered by a Board of Health with the Chief Medical Officer as adviser. The government medical staff in Nassau (the seat of government, situated on Providence Island), excluding the Chief Medical Officer whose work is administrative, consists of seven medical officers, an anaesthetist and an eye specialist. There are six district medical officers in the Out Islands.

Wrought-iron bannisters in main rotunda.

Among the general population, tuberculosis, venereal disease, and malnutrition are major problems. The islands are fortunate in having few tropical diseases and very little poliomyelitis. A new sanatorium is soon to be built where active cases of tuberculosis can be isolated and treated and an intensive educational program carried out. Improved therapeutic measures are reducing the incidence of venereal disease and increased numbers are seeking treatment. Malnutrition is an economic problem and is seasonal in its incidence as elsewhere.

Hospital Service

In Nassau a new public general hospital was completed in 1953, replacing an out-moded structure. At first known as the Bahamas General Hospital, the name was changed in 1955 to that of The Princess Margaret Hospital, on the occasion of the Princess' visit to the islands. With a capacity of 200 beds and 20 cots, the hospital has general

wards for surgical, medical, and maternity cases. There are no nurseries as such, except for isolation purposes, and each mother helps look after her baby which is at her side. Wards vary in size but in the private section nearly all rooms are single and all are air-conditioned. Operating theatres, physiotherapy department, delivery rooms, and mortuary are also air-conditioned. The nurses' classroom, which contains a sound film projector, is sound-proofed.

The hospital has been designed for easy administration and maintenance; and all equipment and furnishing is modern and simple in type. Fresh cool colours predominate in the interior, while the outside of the hospital is painted pale pink with white trim — most attractive in the southern setting. Windows are of louvered glass panels which can be adjusted to admit ocean breezes or closed against occasional rain. Certain of the interior walls between wards and corridors have long sections of louvered glass also so that the breeze can blow right through. It may be noted with interest that, because of the consistently mild climate, no heating system is required.

The hospital was constructed at a cost of £332,000, with an additional expenditure by the government of £50,000 for equipment and furniture. Special equipment, costing a total of £6,000, was supplied through private donations. Hospital rates for private patients range from £2 to £4/10, excluding x-rays; while those for paying public ward patients run from 5s to £1. However, since 70 per cent of patients do not pay, the revenue of the hospital from this source is but 10 per cent of its operational cost.

Paediatrics division has attractive murals.

The out-patient department which is housed in a separate unit serves an average of 500 patients per day, in contrast with 3,000 per month only five years ago. Here, as well as the usual services, are dental, venereal, and ophthalmic clinics. The eye clinic is open at all times for urgent cases and emergencies such as eye injuries.

The Princess Margaret Hospital is under the direction of the Chief Medical Officer, mentioned above, Dr. N. MacLennan; the superintendent, Hubert Knowles; and the Matron, Miss D. Dane. The staff, including professional, administrative, and other personnel, totals 289 persons.

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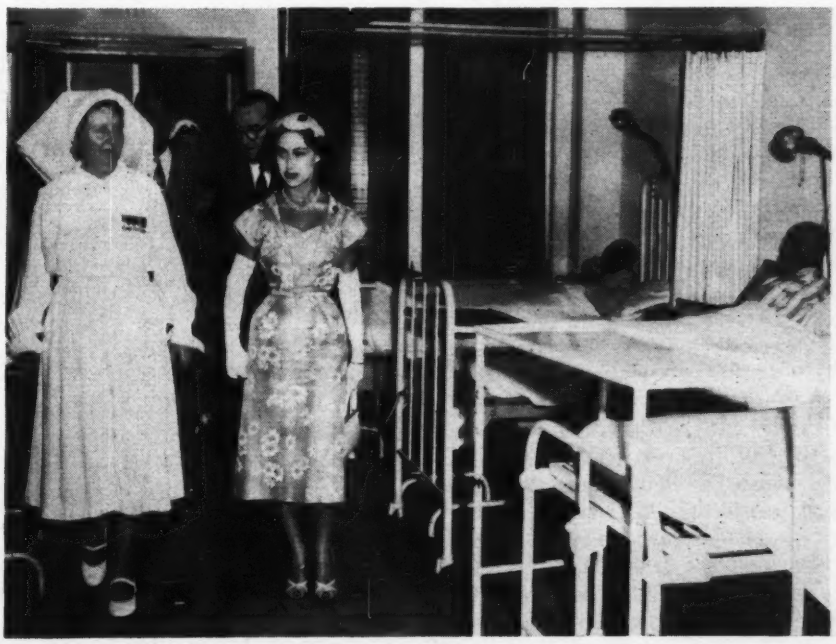


With the Matron, Miss D. Dane and other officials, H.R.H. Princess Margaret inspects the hospital during her 1955 visit to the Islands.

Planned Spending

C. A. Sage, C.P.A.,
Controller,
The Hospital for Sick Children,
Toronto, Ont.

MUCH HAS been written by experts on the subject of budgeting and it is not the intention of this article to set down an authorized text as to the best method. Rather it is to suggest humbly that by using the *Canadian Hospital Accounting Manual* as a basis of accounting and applying ideas and methods chosen for numerous articles on the subject, a budget can help hospitals to know where they are heading financially *before* they arrive at the brink of the deficit chasm.

From time immemorial, people and organizations have been planning their finances in advance hoping to arrive at Utopia — the balanced budget. Caesar had trouble with the Roman Senate about this problem and since then democratic governments always have had to budget in great detail to support taxation among their constituents and hold the votes. Industry and commercial organizations have found it essential if they are to stay in business; and the wise housewife has a few extra dollars left over for stockings and such like, if she plans well with the household food allowance.

Budgeting has done much for those who have tried it and it can do much for hospitals if it is tackled with a reasonable amount of care and has the co-operation of all senior personnel. Looking into the future is never too definite but, from a financial standpoint, good forecasts can be made.

J. Brooks Heckert, Professor of Accounting, Ohio State University, in his "Business Budgeting and Control" quotes E. Stewart Freeman, the well-known exponent of budgeting, as follows: "We can never see the future as clearly as the past but foresight has the one great advantage that it can remedy many things which a more competent hindsight can only regret."

The late Dr. Fred Routley, revered and esteemed by all of us, used to state, more succinctly: "If your foresight was as good as your hindsight, you'd be better off by a damn sight."

The preparation of a good budget is not to be considered as an insurmountably complicated procedure. The extent of the detail which emanates from the results of the budget can be controlled by the accountant or the superintendent, in determining how much information is going to be useful. Many detailed studies must be discarded, in the interest of economy, in the absence of mechanized methods of analysis. This may be particularly irksome to the "curious" hospital officer who likes nothing better than to spend many hours figuring out "what might have been" — but it is of greater importance to keep in mind the chief objective—holding the expense within the amount authorized. This can be accomplished by the application of good accounting, plus the co-operation of all divisions in the hospital. The former is available in CHAM — the latter takes time.

What follows might be placed in three categories: (1) Establishment of sound control of income and expense in the general ledger plus stores and purchasing procedures, as laid down in the manual; (2) Obtaining advance estimates for the subsequent year from department heads; (3) Supplying detailed information to departments for comparison with their budgets.

Accounting Control

To set up a budget such as that of The Hospital for Sick Children, modern general ledger accounting, as set out in CHAM, is strongly recommended. In the beginning, the establishment of a stores requisition system and purchase order method, outlined in detail in the manual, is a requisite. The system here, while now in operation for over four years, follows closely the recommendations of the manual and, judging from experience, works admirably.

The second important step is the recording of *all* expenses, first, *functionally*, by the department in which the expense is incurred and, second, *objectively* by the type of expense, *i.e.* drugs, clothing, food, supplies of various types, telephone charges, fuel, gas, water, steam, et cetera. This information is posted from the copy of the order or from the invoice at the time it is vouchered for payment. The details are recorded in our hospital through the use of a standard book-

FORM 1

Page 1

RECAPITULATION OF ESTIMATES
1956 Direct and Capital Expense

Department _____ Department Head _____

DIRECT EXPENSE	1955 Estimated* Actual Expenses	1955 Approved Budget	1956 Budget Estimate
Personnel (Attach full details of each employee or classification, etc., as indicated on attached Page 2)			
Supplies (Give resume on attached Page 3)			
TOTAL DIRECT EXPENSE	$	$	$
Total 1956 Estimate of Structural Alterations (Page 4)			$
Total 1956 Estimate of Capital Equipment Expenditure (Page 5)			$

Date _____ Signature of Department Head _____

**Estimated Actual Expenses for 1955 are based on 9 months' actual figures projected to one year.*

keeping machine made by a well-known manufacturer. Such a machine is commonly used in many hospitals but, in its absence, the posting can be done by the typewriter or hand in conjunction with a standard ledger card and tray.

We do not propose to expand on basic accounting here as every hospital has its own methods and, with few exceptions, all are applicable to the establishment of a budget.

Obtaining Advance Estimates

A five-part form is used for obtaining departmental forecasts and is indicated here as Form 1. This form embraces:

Page 1—Recapitulation of estimates
" 2 —Staff requirements
" 3 —Supplies and other direct expense
" 4 —Estimates of structural alterations
" 5 —Estimate of capital equipment expenditure

At the end of the first nine months of the calendar year, a trial balance is taken off for each department and within each department totals by the type of expense utilized. These balances are extended on a spread sheet and, by adding one-third to the actual expenditure for each department and type of expense for the nine-month period, a twelve-month total is struck. These informed estimates have proved to be remarkably accurate. The information is then transferred to Form 1 into the first columns of pages 1 and 3. The total salaries and wages estimate is inserted at the foot of page 2. At the same time, comparative figures from the current year's budget are inserted in the second column on page 1 and page 3. The forms are then forwarded to department heads with the request that they estimate their next year's expenditures using not only the information which the Accounting Department supplies but from their own personal knowledge of the operation of their department and their own estimates as to the probable increase or decrease in departmental activity.

Obtaining the above advanced information offers some problems the first year but it is encouraging how well-informed the department head becomes in time to prepare the next budget the following September.

This information must be returned before the 15th of November and it is usually brought into the Controller's office by each department head and gone over in detail, both as to estimates

Page 2

1956 Staff Requirements

Department _____ Department Head _____

Department or section with 20 employees or less kindly list individual names. Other departments may list number of employees under each classification with average annual rate proposed for 1956.

Name or Position	No. of Employees	Proposed Annual Rate—1956 $	Estimated Total 1956 wages per job classification $

Total Salaries budget for 1956 $ _____
1955 Salaries and wages (9 mos. projected to 1 year) $ _____
Average number of employees—(9 mos.)

Page 3

1956 Supply and Direct Expense Budget

Department _____ Department Head _____

Type of Supply or Expense	1955 Estimated *Actual Expenses $	1955 Approved Budget $	1956 Budget Estimate $
Total	$	$	$

**Estimated Actual Expenses for 1955 are based on 9 months' actual figures projected to one year.*

Page 4

1956 Estimate of Structural Alterations

Department _____ Department Head _____

Notes:

1. Give an accurate and detailed description of each item.
2. Estimated unit cost should include any installation charges which might be incurred.
3. It should be understood that estimates submitted below are for the guidance of the Budget Committee only, and Project Requisitions will have to be submitted to the Superintendent in the usual manner.

Description of Proposed Alterations	Estimated cost for 1956 $

Total Budget for Structual Alterations in 1956 $ _____

Page 5

1956 Estimate of Capital Equipment Expenditure

Department _____ Department Head _____

1. Give an accurate and detailed description of each item.
2. Estimated unit cost should include any installation charges which might be incurred.
3. It should be understood that estimates submitted below are for the guidance of the Budget Committee only, and Requisitions will have to be submitted to the Superintendent in the usual manner.

Description of Items	Number Required	Estimated Unit Cost $	Total Estimated Cost for 1956 $

Total Budget for Equipment Expenditures in 1956 $ _____

shown in the report and the reasons for any prognostications made. At this time particular attention is given to proposed increases in the number of personnel or salary adjustments envisaged. Reasons are required for proposed expansion involving either an increase in staff or additional equipment.

The detailed information is now set out on a large spread sheet showing the estimated actual expenditure for 12 months, the previously approved budget (if any), the differences over and under budget, and the figures for the new budget. The spread sheet provides a composite picture for ready comparison of salaries and wages, supplies, special maintenance and utilities.

It is now ready to be discussed in detail with the superintendent of the hospital and, when passed by him, is placed before the Budget Committee of the Board of Trustees for detailed perusal and approval.

When approved, the budget details are sent to the department head by either the superintendent or other senior officer. If any major paring is made in the originally submitted budget, the department head is advised of this change and the reasons for the reduction, otherwise the figures only are provided at this time.

Supporting the Budget

In due course, when the budget has been in operation for three months, Form 2 comes into use to inform the department of the results. We have found that, in transmitting this information to the department heads regularly, there has developed a marked improvement in staff co-operation and employee relations. Almost every department head looks forward to receiving this quarterly report and scans it in detail, very frequently requesting special analyses from the Accounting Department to support the information supplied.

This particular aspect of budgeting is probably the most important of all and the Accounting Department must be prepared to supply a reasonable amount of detail to support the charges indicated. Some department heads are extremely well informed as to the financial operations of their division and frequently take some satisfaction in drawing to the attention of the Accounting Division clerical inaccuracies which occasionally creep in.

For the most part, however, the department head is sincerely interested in watching the fluctuations, both as to expense and income (if it is an income-producing department) in his or her particular section and has in mind next year's budget. The effort to provide this information is well worth while.

It should be noted that, while maintenance and electricity, heat and

(Concluded on page 96)

FORM 2

Comparison of Direct Departmental Expenses with Budget Estimates for the Year to .....

Department .....

	Direct Departmental Expenses Year to Date	Budget Estimates Year to Date	Amount under or over (—) Budget Estimates
Salaries and Wages	$	$	$
Direct Supplies			
Drugs			
Clothing			
Food and Milk			
Housekeeping and Cleaning Supp.			
Bedding and Linen			
Medical, Surgical and Sterile Supp.			
Miscellaneous Supplies			
Printing and Stationery			
Miscellaneous Expenses			
Travel			
.....			
.....			
.....			
.....			
Total Direct Supplies	$	$	$
Totals—Year to Date	$	$	$

Note: Above totals include *only* direct expenses chargeable to your Department and do not include overhead (maintenance, electricity, heat, et cetera).

For trustees only:

Role in a Building Program

Ellis Millard,
Chairman, Board of Trustees, Saugeen Memorial Hospital, Southampton, Ont.

WHETHER you are contemplating the building of a new hospital or an addition to your present hospital, it is most important that you plan for the right number of beds and other facilities. It is just as big a mistake to end up with too many beds as it is with too few. In this connection I would strongly urge that you follow the recommendations of the Department of Health (Ontario) and plan for 5.5 beds per 1000 of population. If you do this you will find that your hospital will fill the needs of your community very well.

When the time comes to plan your actual building program, you would be well advised to follow the recommendations contained in the booklet Behind the Scenes of Hospital Fund Raising, produced by the Ontario Hospital Association. These are outlined under the heading of "The Building Committee". Here is what the booklet has to say on this subject. "The function of and responsibility of the building committee, after consultation with hospital personnel, medical staff, et cetera, is to work closely, first with the architect and secondly, with the builder. Members of this committee should be thoroughly satisfied that architect's plans and drawings are the best obtainable to assure the utmost of efficiency from the building. They should be thoroughly satisfied that every phase and aspect of the building is according to specification and plan, that the materials being used are of good quality and that all possible care is being exercised to assure good workmanship." That, I feel, pretty well sums up the responsibility of the trustee in the construction end of a building program.

Fund Raising

The trustee's responsibility in the building program also includes the all-important matter of fund raising; and let me remind you that today you must assure the government that all the required funds will be available before final approval will be granted for your project. Again I would refer you to the fund-raising booklet mentioned above. Here in the preamble you read this—"There is no magic or secret formula for the raising of money for a hospital, regardless of how appealing the cause may be. Any appeal for funds requires good organization, widespread, favourable publicity, concentrated effort, follow-through and hard work. It also involves a great deal of time, personal sacrifice, persistance and individual effort."

Having gone through both phases of a hospital building program, I can assure you that what is said in this preamble is all too true. However, perhaps you would like to hear some of the plans carried out in the raising of funds for our own hospital. First of all we made up a master list of the names of all the citizens in our town and then divided the town into districts with each canvasser being instructed to call on every home in his district. Canvassers were also given complete facts on the hospital program. They were asked not to consider themselves as canvassers but as salesmen selling the finest product available. They were also told that when making their calls they were not simply to say that they were here asking for a hospital donation, but rather to tell the complete hospital story first, including the cost of the project, and then ask for the donation. This is most important and let me give you a glowing example of how important it really is. During the time of our canvass we had a fairly wealthy person in our town, and the canvasser who called on this party returned with a cheque for $1,000. Naturally I was terribly disappointed in this, so made it a point to call on the party personally. After explaining the cost of building and equipping a hospital, I was able to obtain another $4,000 as a start, and eventually this grew to $27,500 with another $12,500 bequest, making a total of $40,000. So here we have an excellent example of what it means to tell your complete hospital story during a canvass for funds.

A letter sent to all former residents of our town brought in a number of good donations. In fact, one of the first to be received from this mailing was for $5,000. You know the type of letter I mean—"Being a former citizen and knowing that your heart is still with your old home town, et cetera". In your appeals stress the Income Tax deduction feature. In this connection I would recommend that you obtain a supply of the folders on tax savings put out by the Canadian Hospital Association, and use these for special names.

Publish names and amounts of all donations in your local paper, and give special recognition to large contributions.

In our case we were able to obtain some fairly substantial donations by having the donor purchase some specific piece of equipment for the hospital. This resulted in our receiving a larger donation than we would have if the donor had been asked just to contribute to the general fund.

Payroll Deduction

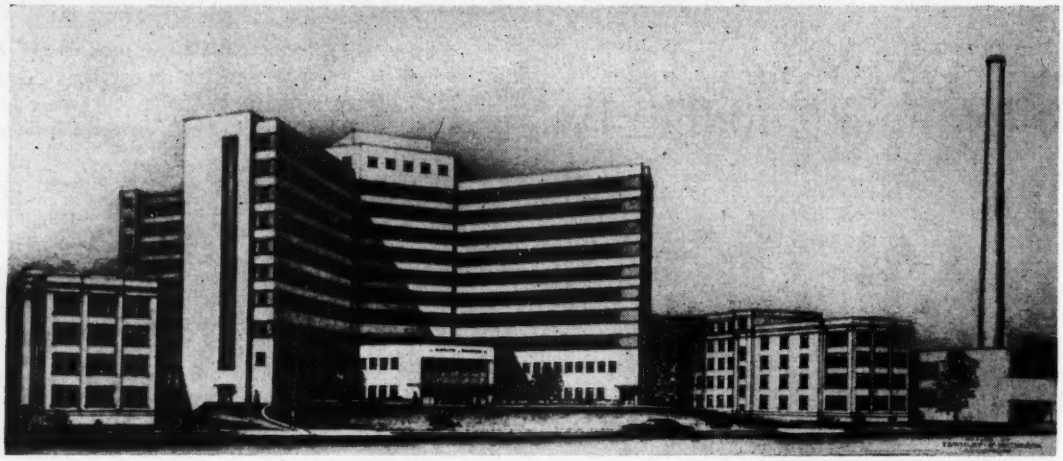
Another excellent method for raising funds is the payroll deduction plan. We were successful in having this plan put into effect in our factories, with payments spread over 12 months. Obviously you will receive a greater contribution through this method than you would by a straight cash donation. In contacting local factories for donations you have the angle of a local hospital being in a position to take care of industrial accidents in a hurry, resulting in less lost time, and of course cutting down on Workmen's Compensation payments.

Be sure that all donations are posted to your master list of names, and follow up those not heard from. You will be surprised at the number of additional donations received when you send out your follow-up letter reading: "According to our records we have not yet received your donation for the hospital."

We also went along with the selling of tickets on various chances and other items of this nature that are usually used in the raising of funds. One of the

(Concluded on page 80)

From an address to the Trustee Section, Ontario Hospital Association Convention, October, 1955.



Architect's sketch—the new "acute block".

Expansion program at the

Vancouver General

J. Norman Robertson
Public Relations Director,
Vancouver General Hospital,
Vancouver, B.C.

THE VANCOUVER General Hospital, emerging as one of the great medical and teaching centres of this continent and the British Commonwealth of Nations, has embarked upon the final phase of a multi-million-dollar building program begun in 1948.

First discussed as far back as 1928, the hospital's "acute block" building, for which tenders were called on May 14th of last year, will provide British Columbia with a diagnostic, treatment, research and educational medical centre, fulfilling every modern concept of care for the acutely ill. Total capacity will exceed 1,800 beds.

British Columbia's great industrial development and expansion, reflected in large part by the recent growth of Metropolitan Vancouver, gave point to an urgent need for greater hospital accommodation—a situation of which citizens and the hospital were both increasingly aware. To the board of trustees of the Vancouver General Hospital, it was evident that a solution could be found only by providing accommodation and services as envisaged over the years in the construction of the proposed "acute block".

The first steps have now been taken towards construction of a 504-bed building, requiring some three years to complete. Designed by architects Townley and Matheson of Vancouver, the cruciform structure of reinforced concrete will ascend nine floors above ground level, with a complete sub-ground floor, partial basement and sub-basement areas. It will be located between the present women's pavilion and private ward pavilion of the hospital. The first three floors plus the sub-ground and basement levels will be mainly allocated to service areas and the remaining floors will be comprised of nursing units.

A new telephone exchange, fully automatic in its operation, will be installed in this building to serve the entire hospital. A complete correlated fire protective system which provides for automatic indicators throughout all buildings of the hospital has been included in the designs. The building itself will be equipped with automatic fire alarm boxes on all nursing floors and in service areas. These boxes will be connected through the telephone exchange and also directly through to a local fire protection agency.

Plans also call for elevators in a central bank, to provide passenger and freight service and a pneumatic tube system to facilitate distribution of messages and records, et cetera, between the various hospital buildings.

In preparation for the eventual construction of the building, the capacity of the power plant was expanded in 1953 to meet the prospective needs. In addition to this building, an adjoining laundry will be constructed to handle all laundry for the entire hospital.

The sub-basement and basement areas of the acute block will be utilized as a central stores area for the entire hospital.

The sub-ground floor will contain a new emergency department, which will replace the present nine-bed emergency unit in the main building. It is proposed to include areas which can be separated by draw curtains and four separate rooms to be used for observation and isolation. Other facilities include a chest survey unit, two minor surgeries, two plaster surgeries, a fluoroscopic room, a treatment room and a public waiting room. To enable fast diagnostic service, one wing of the same floor is designed as a radiology service for this building alone. Accommodation for a housekeeping area, pharmacy, laboratory, and electroencephalography services for this building alone are also planned at this level.

The ground floor level of the building will contain a main rotunda, public waiting room, and an admitting department. Here also will be located offices for the social service department, department of nursing, purchasing and accounting departments, as well as administration offices and a board room.

The second floor is planned to accommodate a central supply room, operating rooms, and a post-operative recovery room. The former will serve the entire hospital, while the latter two will be used mainly for this building alone. The proposed new central supply room will have facilities for cleaning, storing, preparing and sterilizing all dressings, rubber gloves, syringes, surgical instruments and equipment used by the nursing, medical and operating room staff.

Operating rooms, anaesthetic rooms, a laboratory for pathological work which must be done while operations are in progress and an electroencephalography unit have been provided for in operating room areas. All operating rooms have been designed to meet the strictest requirements of hospital safety standards.

The post-operative recovery room will accommodate approximately 14 beds controlled from a central nursing station. Oxygen and surgical suction will be supplied to each bed. As an anaesthesiologist must be immediately available to the post-operative patients at all times, the necessary provisions have been included in the plans.

The third floor is designed for the functions and services of the dietetic department. In the kitchen there will be prepared approximately 5,000 meals a day for this building, the private ward pavilion and the women's pavilion. Food will be distributed to the various floors of this building by means of a tray conveyor and to the other buildings by means of electrically heated food wagons. Also on this floor will be a bakery, salad preparation area, refrigeration compartments for desserts and dairy products.

Six floors, four to nine, have been assigned exclusively as nursing floors. Nursing services provided for each are identical. Control and service areas for patient rooms on floors four to eight, in each of the four wings, have been located in the centre of the building. There will be two nursing stations on each floor, each containing a charting area, control desk, office for the head nurse, medicine room, and other service areas. On each nursing floor will be a dietitian's office, a food service area, a floor supervisor's office, a clinical supervisor's office, a clinic room, equipment storage room, waiting room, male and female lavatory for visitors, and a public telephone booth. A social service worker's office will be located on alternate nursing floors.

A typical four-bed ward will be equipped with two dressing tables, four built-in lockers, over-head separating curtain rails, electrical convenience outlets for each bed, oxygen and suction outlets for each pair of beds and a nurse's call-switch at each bed.

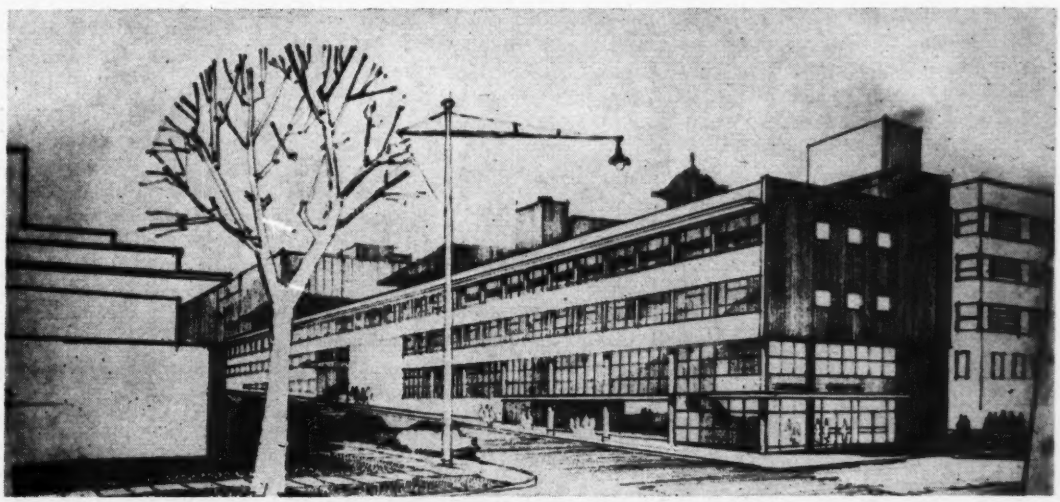
Simultaneously with the construction of the acute block, construction is proceeding on a new two-storey x-ray building adjacent to the existing main building. In addition, the University of British Columbia, Faculty of Medicine, is constructing a most modern three-storey medical school building on hospital property, paralleling the existing main building. Not only will it provide facilities for the medical school, but it will also accommodate the laboratory department of the hospital. Cost of construction for this unit will be met by Department of Health and Welfare grants administered by the Provincial Department of Public Works. ●

New Test for Cancer Detection

A promising new test for the detection of cancer, based on thickening blood plasma, and found to be at least 90 per cent accurate in over 1,700 cases studied, is described in the November, 1955, issue of the *American Journal of Clinical Pathology*. Presence of early cancer, as well as that of the hidden and obscure types that frequently go undetected in routine medical examinations, was reported picked up in as high as 96 per cent of cases, according to Dr. James A. Quinn, Dr. Stanley A. Katz, and Dr. Arthur E. Rappaport of the Department of Pathology and Laboratories, Youngstown Hospital Association, Youngstown, Ohio.

Carpentry — the All-round Therapy

According to Doris Campbell, chief occupational therapist at the Montreal Rehabilitation Institute, carpentry is the most satisfactory all-round occupation in therapy. It is not only adapted to all kinds of handicaps but may be either light or heavy work. "Our main purpose is not to teach patients to make furniture," Miss Campbell said, "but rather to re-educate them in the use of their muscles so that they can participate in normal life again."



Sketch of new medical school now under construction

Catholic Hospital Conference of Manitoba

THE OFFICIAL opening of the Catholic Hospital Conference of Manitoba, held at St. Boniface Hospital, St. Boniface, Man., on October 17th, was preceded by the celebration of the Holy Sacrifice of the Mass in the hospital chapel, by His Excellency, Most Reverend Philip F. Pocock, Archbishop of Winnipeg. Registration took place at the auditorium and 13 member hospitals were represented by 77 registrants. Right Reverend Joseph Robert, Vicar General of the Archdiocese of St. Boniface, expressed His Excellency Archbishop Maurice Baudoux's regret for being unable to be present. Hon. R. W. Bend, Minister of Health and Public Welfare, brought greetings from the Province of Manitoba and His Honour, Mayor Joseph Van Belleghem, expressed a word of welcome from the City of St. Boniface.

During the business session reports were read from the various sections. These dealt with nursing and nursing education; health legislation; and revision of by-laws.

G. Potvin, comptroller of Misericordia General Hospital, gave a very informative talk on current trends and opinions affecting Manitoba hospitals. He said that the prime objective in these general trends was not the dollar revenue but the care of the patient. However, he went further to say that it was by means of the dollar well earned that we can afford competent and efficiently trained personnel and good equipment which will go far in obtaining the best possible patient care.

G. Pickering, comptroller of St. Boniface Hospital, speaking also on current trends, stated that public opinion was crystallizing. He, too, expressed conviction that the hospitals in Manitoba are facing a rather challenging situation. Government health insurance, he said, will be accepted because it is inevitable. He went on to say that it was obviously a wise idea to get the financial records in order because a lot of questions about administration, budgeting, and comptrolling will be asked in the next few years. Governments may be willing to help but if we are to deal with them successfully we must present a cohesive front, he said.

Many interesting topics received attention at the afternoon session. Dr. J. E. Burch, of the Winnipeg Clinic, spoke on "Mental Needs of Patients". He outlined the job of hospital personnel — to help restore mental ease to to the mentally diseased, to help the maladjusted to adjust and direct their activities along socially acceptable channels. He discussed the psychological background of such illnesses and the type of treatments used today; stressing especially the therapeutic value of kindness, consideration, and patience.

Dr. Paul l'Heureux, medical director of St. Boniface Hospital, gave an address on accreditation under the clever caption of "Milestone or Millstone". He outlined the theoretical and practical aspects of this specific field. He said that the need for accreditation is becoming more and more necessary because the public is getting more demanding and the hospitals in turn feel the need of meeting the minimum standards to promote better hospitalization in all its phases in order to give the patient the best possible care.

J. P. Klassen, administrator of Bethesda Hospital, Steinbach, gave an excellent paper on the "Essential Requirements for Accreditation". He laid stress on the following factors required before a hospital can be accredited: namely, a safe physical plant, good administration, competent medical staff, up-to-date medical records, adequate clinical laboratory, x-ray department which is safe and reliable, competent nursing services, and a dietary department with qualified dietitians.

In speaking on the professional secret Rev. Jean Warczak, chaplain of Misericordia General Hospital, Winnipeg, said that "a secret in general is a hidden fact or truth, which cannot be revealed without injustice or uncharity". However, under certain circumstances where the common good must be considered the obligation of keeping the professional secret was not binding, he said. Discretion is important in order to judge whether a secret must be kept or revealed.

Among the resolutions passed at the meeting was one resolving that the Catholic Hospital Conference of Manitoba sponsor an institute on hospital accounting for the Sisters.

One of the highlights of the convention was a conference on "The Hospital and the Alcoholic", by Judge Ralph Maybank, Justice of Court of the Queen's Bench. He pointed out the tremendous need of these patients to be treated in general hospitals as readily as any other sick patient and discussed the stigma which is still wrongfully attached to alcoholics.

Officers

President: Sister Gertrude Jarbeau, St. Boniface Hospital, St. Boniface.

Vice-president: Sister M. Justina, Johnson Memorial Hospital, Gimli.

Secretary-treasurer: Sister Ann Ell, St. Boniface Hospital, St. Boniface.

Directors: Sister St. Odilon, Misericordia General Hospital, Winnipeg; Sister Gouin, Flin Flon General Hospital, Flin Flon; Sister St. Dominic, Sacred Heart Hospital, Russel; Sister Mary Alphonsus, Johnson Memorial Hospital, Gimli; Sister Anna Trottier, St. Boniface Hospital, St. Boniface; Sister St. Maurice, Misericordia General Hospital, Winnipeg.

Spiritual Adviser and Bishop's Representative: Rev. Father R. Durocher, O.M.I., Winnipeg, Man.

Honourable Mention

In the annual report competition sponsored by *Hospital Management*, an honourable mention was given to the report presented by Winnipeg Municipal Hospitals, Winnipeg, Man. The following paragraph is taken from "Annual Report Winners", the magazine's write-up of the contest.

"The results of this year's annual report competition should completely dispel any notion that hospitals with the most money to spend necessarily make the best contenders. One of the selections for honourable mention in the 400-beds or more classification was the report of Winnipeg Municipal Hospitals, Winnipeg, Canada. John McIntyre, administrator of the hospital, informs us that the hospital's annual report was mimeographed and produced at a cost of $162 for printing and $52 for paper and binding —this to supply 250 copies for distribution."

Vale of Leven Hospital, with Loch Lomond in the background

Unit construction a feature of Scottish hospital

VALE OF LEVEN Hospital at Alexandria, Dunbartonshire, Scotland, completed last year, is the first new general hospital to be built in Britain since 1938. It is situated in a sheltered valley, with a magnificent view of Loch Lomond and Ben Lomond from its forecourt.

The hospital has been designed for economic yet efficient staffing and can easily be increased or decreased in size or altered internally without loss of structural unity. It consists initially of 18 standard units, each 100 feet (30.48 metres) long by 40 feet (42.6 metres) broad by 10½ feet (3.15 metres) high. These units are in blocks two-storeys high but additions can be one, two or three storeys. The prefabricated outer wall panels, to a module of three feet four inches (0.4 metres), are interchangeable within five variations. All internal partitions are non-load bearing and can readily be altered to meet medical requirements.

All standard units stem from the three-storey permanent central corridor. The basement corridor gives access to a soiled linen area, to the mortuary and many other services, including oxygen which is piped to theatres and wards.

The ground-floor corridor, the hospital's "main street", links up all departments. The first-floor corridor is used exclusively for food services.

The hospital comprises the wards, operating suite, central sterilizing, central supply, out-patient department, general laboratories, radiological suite, laundry and main kitchen, administrative offices, and staff quarters.

It has 156 beds but can accommodate 280 in an emergency. There are six 26-bed wards, sub-divided into 12 groups of 13 beds. Each group has an eight-bed alcove, a four-bed alcove, and a one-bed room. The beds, and the day-rooms which divide each 13-bed group, occupy the best air and light spaces. Cupboards are plentiful.

Nurses have a clear view of the 13 beds from an elevated L-shaped "station", the farthest bed being only 23 feet away. Ward floors are cork covered and acoustic tiling has been used effectively. Corridors and service rooms are covered with composition flooring.

A link unit serves two 26-bed wards and contains a kitchen with a refrigerator and facilities for making tea, sisters' room, clinical and dressing rooms, linen room, staff lavatories and bed-hoist.

The twin-theatre unit is fully air-conditioned. Each can take two tables in an emergency. A recovery room is also provided.

All supplies are issued from central supply, which adjoins the assistant matron's office, and is adjacent to stores, pharmacy, and the sterilizing centre and is only 300 feet (91 metres) away from the farthest bed.

The spacious main kitchen can provide meals for up to 600 people. Food for 13 patients is sent to each ward group in electric, insulated trolleys and served directly to each bed side. Dishes are returned to the kitchen and washed mechanically. The laundry will serve all the other hospitals in the area.

In the staff quarters there are private suites for the matron, assistant matron, resident doctors, and 72 single bedrooms, with attractive common sitting rooms on each floor.

Daylight lighting, bright contrasts in wall colourings and furnishings, and relatively low ceilings completely dispel that institutional look common to older hospitals.

Cost of the hospital, complete with specialized equipment, is approximately £750,000. A 52-bed ward unit, complete with all ancillary services, works out at £710 per bed, normal spacing. A standard residence unit accommodating 18 nurses in separate rooms and complete with common sitting room, bathrooms, and kitchen-laundryette costs £700 per nurse.

The hospital, which was opened in August, was designed by J. L. Gleave, in consultation with the Western Regional Hospital Board's chief architect and the architects' division, Department of Health for Scotland.

This article was written by John Kerr, Scottish industrial journalist, and appears here through the courtesy of the United Kingdom Information Office, Ottawa.

Home-maker's course in tuberculosis hospitals

Doris Morton,
Chief Dietitian,
Moncton City Hospital,
Moncton, N.B.

IN 1953, the Moncton Home Economics Club was asked to participate in a Home-maker's Course to be given at the Moncton Tuberculosis Hospital. The course was to be part of the rehabilitation program planned for women patients.

Doctors and rehabilitation officers were deeply concerned with the large number of women who, following discharge from hospital, were obliged to re-enter hospital for further care. It was fairly obvious why this was so. All too soon the mother's illness was forgotten upon her return home and once again she was over-burdened with the cares and duties of running a home. It was felt that a home-maker's course might help to remedy this situation. The teachers at the Moncton Tuberculosis Hospital called upon our club to help with this course. We decided it was the most worth-while challenge we had received since our club was formed in 1950 and undertook to sponsor the course.

Once a week lectures were given over the public address system. These were read by one our club members. A synopsis of each talk was given to each patient enrolled in the course and 60 women patients took part. All made scrap-books of lectures, recipes and other printed material that was given to them. Club members visited the wards frequently and talked with the patients as often as possible. Several early evening programs were given, when movies were shown and club members attended to meet the patients enrolled in the course; discuss problems with them, and aid with material for the scrap-books.

As a follow-up to this program a rehabilitation officer visited the homes of discharged house-wives, pointing out to the other members of the family the part they must play in order to keep mother well, at home with them.

The course was given over a two-year period and was divided into three sections as listed below.

Cooking and Nutrition

The section on cooking and nutrition included 16 lectures on the following topics: table setting; milk; fruit; vegetables; meat, poultry, cheese; fish; eggs; bread and cereals; fats; breakfast; dinners; supper; nutrition; methods of cooking; purchasing of food; and menu planning. Two movies, "Food for Freddie" and "Magic Shelf", were shown to supplement the lectures. Prizes of four cook books were also awarded.

Home Management

A section on home management was divided into 14 lectures and the topics discussed were: purchasing food; family budget and household accounts; let's have a family meeting; time and motion study in the home or "save the women"; garden appreciation; care of household furnishings and equipment; soap and detergents; leisure time; the relation of the home to the community; speech therapy; the pre-school child; understanding your school-age child; adolescence; and 4-H clubs.

Clothing and Sewing

The third section on clothing and sewing consisted of 20 lectures on: good grooming; the clothing dollar; figure types; colour; fabrics; weaves; wonder fabrics; care of clothing; stain removal; laundering and pressing; accessories; dressing for the occasion; basic sewing tools; pattern study; fitting and altering patterns; demonstration of laying of pattern; clothing construction; darning and patching; demonstration of use of sewing machine; and a movie on "Spring Fashions". Ten practical demonstrations were given on sewing. Two sewing machines were purchased for this course and four sewing baskets were awarded as prizes.

In 1954, five tuberculosis hospitals in New Brunswick and one in Newfoundland adopted this course and over 400 patients participated. Lessons were given in English and French.

In 1955-56 the home-maker's course is being given during a 12-month period as many patients are hospitalized for a shorter time than formerly. ●

Food Service

sponsored by the

Canadian Dietetic Association

"Purchasing and Storeroom Procedures and Controls"

A 27-page manual on the above subject has been prepared by the Council of Administrative Practice of the Texas Hospital Association, 2208 Main Street, Dallas, Texas. In compiling the manual, the Council had special assistance from E. W. Gehrke, director of procurement and supplies, Baylor University Hospital, Dallas.

In the foreword, Mr. Gehrke states: "It has been proved that a central storeroom, with central purchasing (which may or may not include foods and/or pharmaceuticals) and inventory control, can save a hospital many thousands of dollars. The only expense involved is an initial one, when the program is set up." He adds further: "Budgetary control of supplies can be most effectively maintained by a close relationship between the procurement and supplies department and the accounting department." The latter thought is enlarged upon in Section I which deals with storage control.

A second section contains 14 sample forms, suggested for use in purchasing and storeroom procedures, and these are worthy of study. There follows, in succeeding sections, a concise outline of purchasing procedures, an adaptation of the procedure for the use of smaller hospitals, and directions concerning property control.

While this manual was prepared as a service to members of the Texas Hospital Association, it may well be of interest and use to many others inasmuch as it is meant to be a guide for the checking of policies and for the evaluation of new ideas.

◀ Provincial Notes ▶

Nova Scotia

MUSQUODOBOIT HARBOUR. The Red Cross Twin Oak War Memorial Hospital here, 25 miles east of Halifax, closed its doors recently after the superintendent and staff, consisting of three nurses, resigned. The superintendent, Helen Bigelow, and her staff requested and were given transfer to another Red Cross outpost hospital in the province. Twin Oak War Memorial Hospital is one of 11 operated by the Red Cross in Nova Scotia, and will remain closed until a new staff can be recruited.

New Brunswick

MONCTON. The financial position of Moncton Hospital is "today about $150,000 better off than it was a year and a half ago", according to reports presented at a recent meeting of the hospital's board of directors. The financial situation has been improving steadily and the hospital is now within about $1,300 of breaking even on operating expenses. Long-term patients on the list have decreased and old accounts are being brought under control, it was revealed.

Quebec

HULL. The provincial government will begin construction soon on a new hospital for chronic patients here, it was announced recently. It will be built near the new Hôpital du Sacré-Coeur, now under construction. Cost of construction and subsequent operating expenses will be assumed by the provincial Ministry of Health, while the Sisters of Sagesse will run the institution.

* * * *

MONTREAL. Patients and staff of the Royal Victoria Hospital began moving into the hospital's new $5,000,000 wing in December. The 274-bed wing is part of a current building and renovation program and brings the hospital's total capacity up to 850 beds. The eventual capacity will be close to 1,000. The wing was built through funds provided by a Royal Victoria Hospital campaign held in 1951; renovation of the main building is the next item on the program. Total cost of the long-term development plan is estimated at some $14,000,000, including the new wing and extensive alterations made to the hospital's Allen Memorial Institute of Psychiatry a few years ago.

* * * *

MONTREAL. Ground was broken in November for a new addition to the Jewish Hospital of Hope, a non-sectarian institution for chronically ill patients. The addition, the first of two new wings to be constructed, will cost about $350,000 and is expected to be completed in August. It will provide certain service facilities, two solaria, and space for 42 beds, bringing the hospital's total capacity to almost 130.

* * * *

MONTREAL. The annual maintenance campaign of the Queen Elizabeth Hospital of Montreal went over the top last November with donations reaching a total of $111,548. The campaign's objective was $110,000.

Ontario

BROCKVILLE. St. Vincent de Paul Hospital is going ahead with plans for an addition to the present building. The expansion project will cost about $580,000 and will increase the hospital's capacity from 83 to over 150 beds. Space for 24 more bassinettes, a new out-patient emergency section, and larger quarters for other departments will also be provided.

* * * *

COCHRANE. Lady Minto Hospital's new $350,000 addition was completed and opened recently. It adds 26 beds to the hospital's capacity of 82. The institution has been badly over-crowded for some time and the main building, constructed in 1915, was intended to accommodate not more than 45 patients.

* * * *

CORNWALL. Ontario Hydro's St. Lawrence power project hospital, two miles west of here, was officially opened recently. One of a series of small hospitals built by Hydro on construction projects, it has a 30-bed capacity and the usual ancillary services found in institutions of similar size. It provides on-the-spot service, both medical and surgical, for construction workers and other staff. Sections of the building have been in use since July, 1955.

* * * *

DUNNVILLE. A new 12-bed nurses' residence is to be built at Haldimand War Memorial Hospital. Tenders have been called for the project, which is expected to cost about $70,000.

* * * *

GALT. The new extension to South Waterloo Memorial Hospital was completed and opened recently, adding 45 beds to the hospital's capacity. The hospital previously had a total of 172 beds. The addition consists of a third and fourth floor on the west wing. Approximate cost of the project was $165,000, excluding furnishings.

* * * *

GUELPH. A new $650,000 nurses' residence is to be built at Guelph General Hospital in the near future. The plan now under consideration calls for a four-storey building with accommodation for 103 nurses. Another building, large enough to take care of more nurses, if necessary, is also to be constructed for use as a training school. The buildings will be joined to a small central structure, where reception rooms and offices will be set up.

* * * *

MOUNT FOREST. The new wing to the Louise Marshall Hospital was completed and opened recently by the Hon. Mackinnon Phillips, M.D., minister of health for Ontario. Cost of the addition, including equipment and furnishings, was about $60,000.

* * * *

NORTH BAY. North Bay Civic Hospital hopes to double its capacity soon with a 100-bed addition. Although the hospital was built only three years ago,

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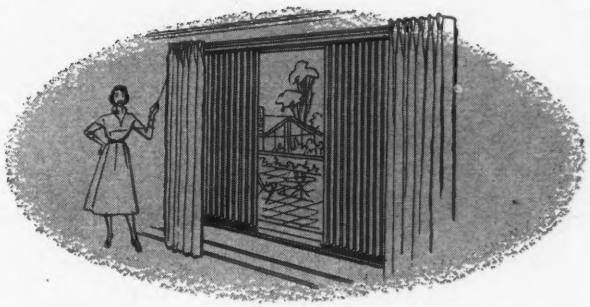

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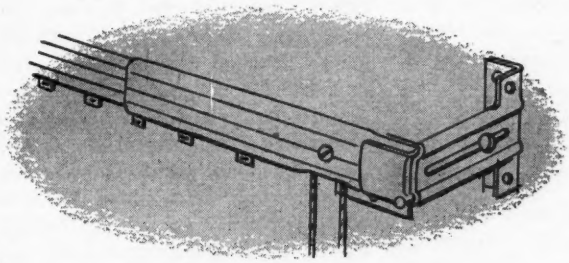

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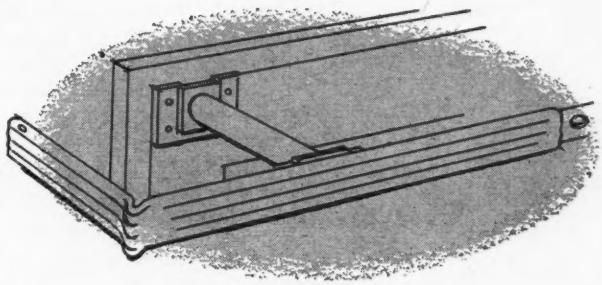

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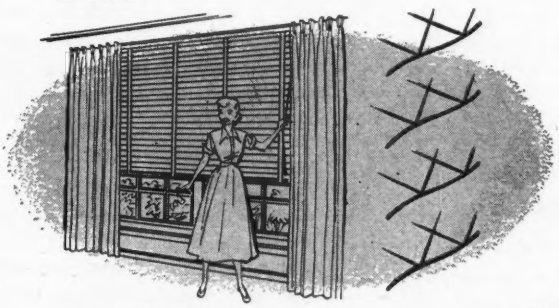

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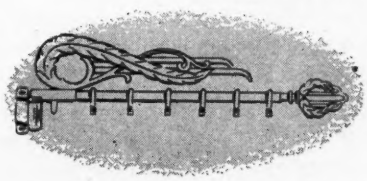

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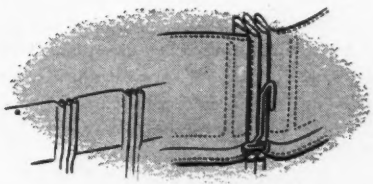

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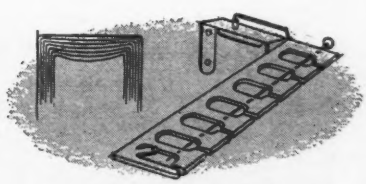

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a steadily increasing population has already resulted in a shortage of hospital beds in that city.

* * * *

OTTAWA. Plans for a $3,200,000, four-to-five year expansion and renovation program are now being made by Ottawa Civic Hospital. The project will increase the hospital's present capacity by 300 beds, including a 40-bed psychiatric unit. Among the improvements contemplated are construction of a four-floor addition on top of the Pathology Building, two three-storey additions to existing buildings, and the addition of a second and third floor to the extension at the north end of the hospital's west wing.

* * * *

ST. THOMAS. The new Memorial Hospital Wing at St. Thomas-Elgin General Hospital was opened early last November. The wing, a unit for chronically ill patients, will be operated by the board of directors of the general hospital. It provides space for 79 long-term patients who were previously accommodated on the fifth floor of the older building. Only two of the wing's three floors are in use at the present time.

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SUDBURY. The Hon. Leslie Frost, Premier of Ontario, recently opened the new Sudbury Memorial Hospital. Construction of the 225-bed institution began last summer.

* * * *

TORONTO. Doctors on the staff of the Toronto East General and Orthopaedic Hospital recently pledged themselves to raise $75,000 for the hospital's $3,000,000 building campaign which is to begin in the spring. The pledge amounts to about $1,200 for each doctor. Funds raised in the campaign will go toward construction of a new 250-room wing.

* * * *

TORONTO. The Hon. L. O. Breithaupt, lieutenant governor of Ontario, officially opened the new $650,000 addition to Humber Memorial Hospital in November. The new 75-bed extension more than doubles the capacity of the hospital and also provides space for certain service facilities. The addition was designed for expansion to double its present size, if the space is required in the future.

WINGHAM. The new 50-bed wing for chronically ill patients at Wingham General Hospital was completed and opened officially last month. Cost of the wing was about $290,000.

* * * *

WOODSTOCK. The new three-storey wing to Woodstock General Hospital, which has been completed for some time, was opened officially in November. The 55-bed addition was built at a cost of some $1,500,000 and has increased the hospital's capacity to 155 beds. It has also made possible the addition of an emergency department.

Saskatchewan

PRINCE ALBERT. Opening ceremonies were held in November for the new nurses' residence and school at Holy Family Hospital. Approximate cost of the 80-bed institution was $500,000. It replaces the old 40-bed residence which will no longer be used.

Alberta

BARRHEAD. The new 60-bed addition to St. Joseph's Hospital was opened officially last November. The L-shaped structure, which has a split-level design, cost about $487,000, including equipment. It is a far cry from the first Barrhead hospital, which was a converted blacksmith shop, and the old 34-bed hospital, opened in 1934, has been badly overcrowded for some time. The architects for the structure were Diamond, Dupuis, and Dunn, Edmonton.

British Columbia

ASHCROFT. The new addition to Lady Minto Hospital is now under construction and will be completed soon. The 14-bed extension will more than double the hospital's present capacity and will also have sufficient service facilities to make it a unit in itself. Construction costs for the addition total $59,800.

* * * *

CHILLIWACK. Plans are now well under way for a new nurses' residence and a $1,500,000 addition to Chilliwack General Hospital. The addition will increase the hospital's capacity to 135 beds, while service facilities will be provided for a 175-bed capacity. The structure is also designed for future expansion which will add another 40 beds. A 36-bed nurses' home which will cost about $70,000 is included in the current program, while the former army hospital now serving as an annex will be demolished. Architects for the structure are Sharp & Thompson, Berwick, Pratt, Vancouver.

* * * *

INVERMERE. The first sod was turned late in October for the new Windermere District Hospital here. The 23-bed institution will cost about $248,000 and the building program calls for completion of the structure by April. The hospital has been in the planning stage for more than two years. Tenders will be called in the spring for a staff residence.

* * * *

NEW WESTMINSTER. Tenders for construction of the new $2,220,000 St. Mary's Hospital were called in November and work on the structure was expected to begin soon. Plans call for a total of 109 adult treatment beds and 26 children's beds, while allowance has been made for an additional 150 beds when required. The existing hospital will be demolished and the space used as a parking lot when the new building is completed.

* * * *

PORT COQUITLAM. Scheduled for completion in February, 1957, is a three-storey mental hospital for the aged. The institution will accommodate 288 patients and will also provide for an auditorium, day rooms, and physiotherapy facilities.

* * * *

SURREY. Preliminary plans for a new hospital here provide for a 60-bed institution on the double corridor plan. It is to be a three-storey structure with the basement serving as the first floor, due to the nature of the site. Surrey has no hospital at the present time.

* * * *

TRAIL. Plans are now under consideration for a new hospital for long-term patients, to be constructed on the grounds of the Trail-Tadanac Hospital here. The hospital will have a 50-bed capacity, and construction costs are estimated at about $250,000. It will have a separate management, but would be able to rent certain facilities from the Trail-Tadanac Hospital.

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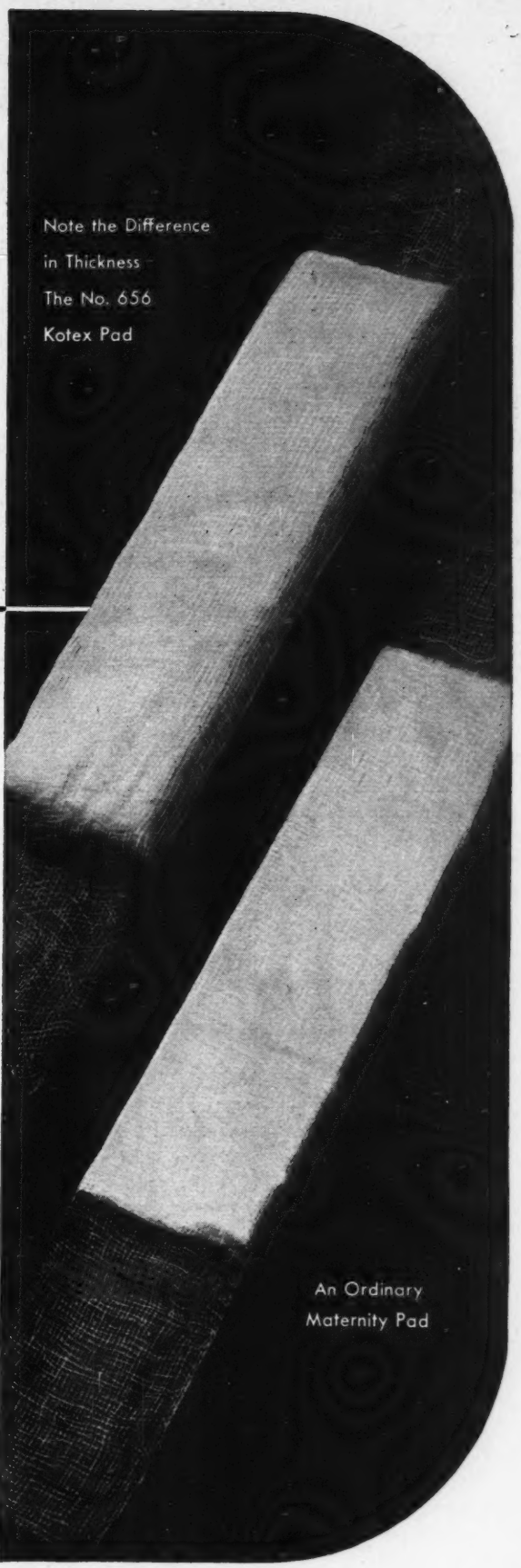

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With the Auxiliaries

Report from Saskatchewan

Representatives of 61 Saskatchewan auxiliaries met last October at the 14th annual convention of the Saskatchewan Hospital Auxiliaries Association, which was held at the Bessborough Hotel in Saskatoon. A total of 123 delegates and visitors registered for the convention.

The report of the secretary-treasurer, Mrs. Drake, Tisdale, showed that $70,315.79 was raised during the year by 95 auxiliaries. A $100 scholarship for student nurses, sponsored by the association, was won by Faye Spencer of Wadena. Miss Spencer spoke to the delegates in the afternoon on the nursing course she is taking, while Hazel Keeler, director, School of Nursing, Saskatoon, discussed "The Advantage of University Preparation for Nursing."

At the Wednesday morning session Dr. Arnold L. Swanson, superintendent, University Hospital, Saskatoon, spoke on "Establishing the Objectives and Organizing a Hospital Auxiliary." Dr. Swanson described an auxiliary's most important function as public relations and offered many suggestions as to how the auxiliary could give service to both patients and the hospital itself. An auxiliary should have a "broad membership", stated Dr. Swanson, in order to be truly representative of the community.

Judge J. M. George Morden, Man., was the next speaker and chose as his topic "What Is Past Is Prologue." Judge George asked the delegates to continue the great work they were doing, which was merely "the introduction of great things to come."

Lorraine Wright, senior instructress for nursing assistants, Canadian Vocational Training Schools, spoke at the Wednesday afternoon session on the progress of nursing assistant training which has been necessitated by the present shortage of registered nurses.

Officers, 1955-56

Past President: Mrs. G. Wright, Balcarres.
President: Mrs. J. N. Adams, Tisdale.
Secretary-treasurer: Mrs. K. B. Drake, Tisdale.
Vice Presidents: Mrs. W. C. King, Estevan; Mrs. E. H. Henley, Saskatoon; and Mrs. W. Dier, Prince Albert.
Provincial Liaison Officer: Mrs. P. I. Korman, Saltcoats.
Advisory Councillor: Mrs. W. B. Frost, Melfort.

* * * *

Three B.C. Auxiliaries Hold Annual Bazaars

Annual bazaars were held last November by three women's auxiliaries in Victoria, B.C. Goods featured at the bazaar sponsored by the Junior Auxiliary to Royal Jubilee Hospital ranged all the way from plants to stuffed animals, while a tea was also held.

The Gorge Road Hospital's auxiliary also held a poinsettia bazaar and tea at about the same time. The $700 raised through this project will go toward the extension of physiotherapy and occupational therapy services for the rehabilitation of elderly patients at the hospital.

The annual bazaar and tea sponsored by the women's auxiliary to St. Joseph's Hospital displayed many attractive goods for sale. A total of $3,161.20 was taken in during the afternoon.

* * * *

Mrs. W. C. Mikel, a past president and honorary life member of the Women's Hospital Auxiliaries Association of Ontario, holds the "Book of Memory" which honours outstanding members of the association. Mrs. Mikel has been active in auxiliary work for over forty years.

New Ideas from Manitoba

Many original ideas were to be found at the Fun Fair held last autumn by the Women's Auxiliary to Pine Falls Hospital, Pine Falls, Man. Among the special features were a pre-fair parade and pony rides for the children. Clowns sold balloons and novelties, while a side-show drew crowds of all ages to view the two-headed boy (twins in a large suit) and a wild man. An oil well game was also introduced—a box of sand with a small vial of oil buried in it. Customers purchased small flags on sticks on which they wrote their names, then plunged the stick into some part of the sand. The stick closest to the oil, of course, carried off the prize.

* * * *

Rummage Sale Aids Shrine Hospitals

A regular deparment store bargain sale took place last fall when the Ladies' Auxiliary to Shrine Hospitals for Crippled Children held their annual rummage sale in Calgary, Alta. A new feature of the sale was a farm produce section where fresh fruits and vegetables, preserves, and other farm products were sold.

* * * *

New Auxiliary Holds First Event

The Women's Auxiliary to St. Bernard's Convalescent Hospital, Toronto, held its first event, a get-acquainted party for friends of the hospital. The auxiliary hopes to increase its membership and plans to concentrate on one big fund-raising project a year, a garden party in the summer.

* * * *

"Here Comes Charlie"

A rather unusual fund-raising project was sponsored in the fall by members of the auxiliary to St. Bartholomen's Hospital in Lytton, B.C. This group, assisted by the community, put on a play, "Here Comes Charlie", in order to buy a badly needed oxygen tent for the hospital. The comedy played two nights, with the result that there was enough money left over to purchase several other items of equipment as well.

* * * *

New Auxiliary in Saskatchewan

Women representing various districts, including an RCAF station, in Moose Jaw, Sask., convened recently

(Concluded on page 88)


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Book Reviews

AIRBORNE CONTAGION AND AIR HYGIENE; AN ECOLOGICAL STUDY OF DROPLET INFECTIONS. By William Firth Wells. Price $6.60. Pp. 423. Harvard University Press, published in Canada by S. J. R. Saunders & Co., Ltd., Toronto, 1955.

For seventeen years in the laboratory for the study of airborne infections at the University of Pennsylvania School of Medicine, and for five years before that at Harvard University, William Firth Wells has pursued the study of airborne contagion; the published results of his efforts, outlined with postulates, relevant experiments, and the resulting inferences, make the book not only a valuable scientific document, but a work of clear, practical importance. The development of methods of sanitary control by air disinfection should prove of particular interest to sanitary engineers, health workers, surgeons, and hospital administrators.

Divided in two parts, the first section is an analysis of "Airborne Contagium", detailing the physical chemistry of droplets and nuclei, the biology, biophysics and biochemistry of droplet nuclei infection and disinfection, the physiology and parasitology of droplets and nuclei contagium. Part II is entitled, "Air Hygiene", and lays down the principles of sanitary ventilation, going on to air hygiene, dustborne infection, and the ecology of droplet infections.

The theory that infected droplets settle on exposed surfaces within an area of three feet is disputed strongly; the presentation demonstrates that infected persons expel many droplets into the atmosphere which immediately evaporate, but leave germ-bearing nuclei to drift about until inhaled or vented, or until they die. The chance of breathing disease germs out of doors is almost negligible, but the amount of shared air breathed in a lifetime (estimated at one million cubic feet per person) is an enormous total, and it is particularly in this atmosphere, with closed windows in the winter months, that respiratory diseases spread to epidemic proportions. It is here that sanitary precautions are of particular value.

The problem of cross-infection in the hospital, of protecting burns, of the dangers of dust from infected bedding, et cetera, are discussed. Lightweight curtains in front of, and above the cubicles provide a radiation barrier, it is reported, which prevents more than one per cent of test organisms in droplet nuclei from passing through. Air disinfection can be a sanitary equivalent to ventilation, it is stated, and the extensive discussion of ultraviolet lamps in varied hospital uses should prove of real interest to hospital personnel; chemical disinfectants in the air seem to be of less conclusive value.

One needn't be a specialist in physiological hygiene to appreciate the contents of this book. The layman scientist, the hospital administrator, and the interested health worker will probably find it of interest, particularly the practical suggestion for controlling disease insofar as the air provides the media of transportation.

—*R.J.M.*

MANUAL FOR MEDICAL RECORD LIBRARIANS: By Edna K. Huffman, C.R.L. Fourth edition. Pp. 604. Price $9.75. Published by the Physicians' Record Company, Chicago, Ill., 1955.

The fourth edition of this manual contains added and revised material pertaining to the most recent developments in theory and practice. These changes make it an invaluable reference for medical record librarians, students, and administrative personnel, alike.

The following are some examples of additional material which may be cited as enhancing the value of the textbook: History of the standardization movement and accreditation program; organization and duties of tissue committee; most recent ruling of the Joint Committee on the Accreditation of Hospitals regarding consultations; and method of terminal digit filing of patients' records. An important addition is the inclusion of arithmetic examples to clarify the computation of percentages in the chapter on "Collection of Statistical Data." A guide to the number of medical record personnel needed in hospitals of various sizes and the equipment consequently required, has been added in the chapter on "Organization and Management."

Some of the topics which have been revised are: medical record and medical audit committees; microfilming procedure; coding according to the fourth edition of the Standard Nomenclature of Diseases and Operations; and the phonetic system of filing patients' index cards.

From the foregoing, it may be determined that this edition of the *Manual for Medical Record Librarians* will greatly assist all who are interested in medical record work.—*Doris McPherson.*

HUMAN RELATIONS IN NURSING. By Wayland J. Hayes, Ph.D., Professor of Sociology, Vanderbilt University, and Rena Gazaway, R.N., B.S.P.H.N., M.A., Assistant Professor of Nursing and Health, University of Cincinnati. 471 pp. Publishers, W. B. Saunders Company, Philadelphia and London. Price $4.50.

In their preface the authors state that the purpose of the book is to arouse interest and curiosity about matters which are so familiar that they are often overlooked. Students are encouraged to detach themselves as completely as possible from their own society and to look in upon it much as a stranger would do. Students are introduced to a systematic plan for reviewing the orderly relationships in society, and they are given the principle concepts by which they are able to analyze social systems in considerable detail. The book is designed particularly to help nurses gain maximum insight concerning the human relationships involved in their professional service; and the second part of the volume is applied entirely to that end. A large number of situations in which nurses are related to colleagues in health services, to varied types of patients in diverse social situations, and to the larger community relations, are explored for greatest understanding of all social factors involved. Upon such analytical foundations, courses of action which promise the optimum health of society are set forth.

The book is divided into two main parts: Part One deals with sociological orientation and contains eleven chapters: Part Two, "Sociology Applied to Nursing", contains thirteen chapters. At the end of each chapter is a section for investigation and discussion, and a bibliography,—*W.D.P.*

Here and There

First Post-War Welsh Hospital

The first Welsh hospital to be built since the start of Britain's National Health Service, and the first since the war, was opened recently at Rhyd-lafar. It is known as the Prince of Wales Orthopaedic Hospital, named after, and a branch of, the well-known hospital in Cardiff.

The development of the Prince of Wales Hospital, Cardiff, had been planned many years ago. A small country branch was opened in 1929 at Crossways, near Cowbridge. This was not large enough for requirements, and plans were made to expand this small hospital and make Crossways the site of a major unit.

The war intervened before any progress could be made. The end of the war brought no sign that this plan would be realized in the immediate future.

During the war, however, an American service hospital was built at Rhyd-lafar. After the war, there were many suggestions for its use. Because of a serious shortage of orthopaedic beds, the Prince of Wales Hospital was granted the site. Even then, a few years went by before permission was finally granted for a scheme to begin.

The U.S. hospital followed the usual war-time pattern, with corrugated iron nissen huts connected by concrete roads and paths. The re-planning necessitated many changes. The buildings had to be rearranged, some of them being needed to accommodate nurses. The task was made slightly easier because the bed complement of the new hospital is much smaller than it was as an American hospital. The new scheme called for 350 beds (later reduced to 220 for financial reasons), whereas the service hospital accommodated 850 patients.

Using the original foundations, the nissen huts were replaced with standard concrete buildings for wards. Brick structures have been built to house certain essential services (boilerhouse, linen room, et cetera.) Corridors have been widened and in some cases heated. The wards are spacious and light and have French windows.

The hospital began to be occupied long before it was officially opened. In 1953, patients were transferred from Cardiff to newly-completed wards, and more were installed as building progressed.—*A. Whiteman.*

Mexico Receives Aid for Malaria Eradication

Of the $3,375,000 recently allocated by the United Nations International Children's Emergency Fund to aid seven countries in the eradication of malaria, Mexico will be the main beneficiary. She is to receive 71 per cent, or $2,400,000, of the funds earmarked for the project. Mexico's situation is regarded as the most urgent as malaria covers three-fourths of its geographical area and represents 52 per cent of the total malaria mortality. The sum allotted by UNICEF will initiate a five-year program to eradicate the disease which will be sponsored jointly by the Mexican government, the World Health Organization, and the United Nations' technical assistance program. The passage of the measure marks the realization that controlling malaria is no longer sufficient because of growing insect-resistance to DDT, the most effective weapon now available for prevention of the disease.

Cobalt Bomb for Burma

Burma is to receive a cobalt bomb for cancer treatment from Canada under the Colombo plan, it was revealed recently. The project will take about two years to complete and will cost around $80,000, including installation and the training of operating personnel. During the past five years Canada has contributed some $133,000,000 in aid to Colombo Plan nations, most of this sum going to Pakistan, India, and Ceylon.

Needy Maltese Patients Receive Treatment in England

In response to an urgent appeal from the Government of Malta, certain needy tuberculosis patients were received for hospital treatment in England recently. They are cases which need hospital treatment on modern lines which cannot be provided in Malta until a new sanatorium has been built there. Plans for a new sanatorium are now under discussion. The Maltese government is sending a few medical officers for training in tuberculosis work, a number of trained nurses and other staff, in addition to the patients. The government will defray the expenses of treatment. — *The Hospital, October, 1955.*

Cardiovascular Training Centre Now Established

Plans for the establishment of a pilot cardiovascular training centre for nurses have been announced by the Public Health Service, U.S. Department of Health, Education, and Welfare. The centre is located at the University of Minnesota School of Public Health, and opened at the beginning of this month.

Nurses for the first group to train at the centre are drawn mainly from the consultant, supervisory and instructor positions. The purpose of the centre is to give nursing leaders a better understanding of new developments in the cardiovascular field and of how to apply these developments to the nursing care of patients, both in the home and hospital.

Something New from Holland

In Holland a hospital bed is available in which the conventional steel-wire or chain spring is replaced by interwoven strips of natural rubber stretched over a framework of stainless steel tubes. This is comfortable for the patient; the ventilating under-layer allows the air to enter and prevents bed sores. The thick upper mattress is eliminated and a thin covering mattress is sufficient. This bed is extremely practical, being light, dust-free and hygienic. Since this rubber webbing provides ample support, it is also used for back and leg rests, stretcher coverings, reclining-chairs, wheel chairs and invalid carriages.

Evaluating the Size of a Hospital

AT THE ANNUAL conference of the American Association of Hospital Consultants, held last fall in Atlantic City, the professional session was of special interest. With the then president, G. Harvey Agnew, M.D., as moderator, a panel of five members of the association opened the discussion of a hypothetical problem which had been developed some months previously by the program committee consisting of Albert W. Snoke, M.D., Anthony J. J. Rourke, M.D., and James Russell Clark.

The theme — evaluating the size of the hospital in relation to community values for patient care, education and research.

The problem — a hospital community has a choice of building two hospitals of 175 beds each or one of 350 beds. Consideration is being given to a merger of two or more existing hospitals.

Benefits which might accrue to the community and problems which would need to be considered in order that the community may reach a sound conclusion were fully discussed in five particular areas; relation of size to capital expenditure per bed, size as related to quality and comprehensiveness of medical care, size in relation to fiscal operation, relation of size to medical education and to research. The discussion of each aspect of the problem was opened by one of the panel composed of Otis N. Auer, E. Dwight Barnett, M.D., C. Rufus Rorem, Ph.D., Basil C. MacLean, M.D. and Vane M. Hogue, M.D.

It was pointed out by panel speakers that a hypothetical problem could hardly include all the situations which would be likely to develop in any community faced with a similar problem. Each has its own particular problems and no fixed pattern fits all situations. Nevertheless some general observations were possible.

Mr. Auer pointed out that increase in the size of hospitals made some economies of construction possible, but he also drew attention to the fact that actual over-all costs per bed of large hospitals were usually higher than for those of medium size. One explanation is that larger hospitals often provide broader facilities than do smaller ones. Also the very magnitude of some hospitals requires extensive communications and controls not necessary in smaller ones.

"Patient care" said Dr. Barnett "is affected by the type of medical staff organization, the amount of time the staff physician can spend at the hospital, the time required to travel from one hospital to another to care for patients and the necessity of attending meetings in multiple hospitals". The stimulation to medical staffs of having two hospitals instead of one was brought out in the discussion. However, some felt that members of the same staff stimulated each other to an equally important degree. The advantages of full-time over part-time heads of ancillary services and the relationship of these heads of departments to the medical staff as a whole were evaluated.

That fiscal operation is influenced by the planning of the building as well as by the competence of the administrator was emphasized by Dr. Rorem. High utilization of beds, which increases revenue above cost, is dependent upon flexibility of patients' accommodations. Rooms with too many beds defeat this objective. The difference in administrative techniques required to administer small, medium, and large hospitals efficiently, and the importance of the administrator's philosophy in developing a working organization was particularly stressed. Dr. Agnew, Dr. Barnett and James A. Hamilton, as directors of courses in hospital administration, were well aware of this problem and felt that emphasis was being placed on these differences. Operational costs are higher in the small hospitals if services are provided comparable to those found in a larger hospital.

Dr. MacLean, pointed out the more favourable position of large hospitals in obtaining a desirable quota of house staff and the greater possibilities of a good house and attending staff organization. The use of the house staff in the care and treatment of private patients was strongly supported during the general discussion, although it was recognized that there was resistance to this approach in some of the hospitals, particularly those outside metropolitan areas. A larger hospital lends itself better to teaching.

Very illuminating statistical information on the number and size of hospitals conducting research under special grants from government and private sources was presented by Dr. Hogue. Over 650 grants were made to about 120 hospitals and allied organizations for a total of about $9,000,000 in 1954. Both medical and administrative research problems are under investigation in independent as well as teaching hospitals in a wide range of bed capacities. In the general discussion it was stressed that some excellent research is being conducted in hospitals of modest size although the advantages of mass data available in larger institutions are obvious.

Attended Advanced Institute

Among Canadians present at the Sixth Advanced Institute for hospital administrators held recently in Chicago, Ill., were the four women pictured above: Sister Catherine Gerard, superintendent, Halifax Infirmary, Halifax, N.S.; Flora M. Lamont, director, Shriners' Hospital for Crippled Children. Montreal, P.Q.; Eugenie M. Stuart, M.H.A., Associate Professor of Hospital Administration, University of Toronto, Toronto, Ont.; and Rahno M. Beamish. director of nursing, Kitchener-Waterloo Hospital, Kitchener, Ont.

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Unions Come to Hospitals

(Continued from page 35)

atchewan where labour has steadfastly refused to accept the principle of compulsory arbitration of disputes arising out of the operation of a collective agreement. That is not to say that a union in Saskatchewan might not agree to such a term being included in an agreement but, unlike the other provinces, the law in Saskatchewan does not require that differences arising out of the operation of the agreement be settled in a peaceful fashion and without stoppage of work.

Impact of Unions on Hospitals

Having dealt with the events likely to arise when a union starts an organizational drive, it now becomes possible to consider some of the effects of unionization of hospital employees.

Financial

In the first place unions will probably put a heavier strain on hospital finances. To compete in the labour market and to keep within legislative requirements on minimum wages, vacations with pay and so on, labour costs have increased a good deal in the past 10 years. They now take something between 60 and 70 per cent of the total hospital budget. A union will probably take a larger slice unless the hospital negotiators are good bargainers. Whether this will have to be passed on to the patient or whether hospitals will have to seek higher governmental grants or effect economies in some other part of the budget is not for the writer to say. There seems little doubt however that hospital management will have to face this problem and should, perhaps, start considering ways and means before the beginning of an organizational drive by a union.

Personnel

There are some compensating factors. Collective agreements usually help to stabilize personnel problems. It must not be forgotten that every agreement must be for at least a year's duration and if the hospital is a good negotiator it may even get a two- or three-year contract if considered desirable. Thus labour costs are set for a fixed period. Again these agreements relieve the administration of having to bargain with each individual employee.

Another factor which must not be overlooked is that the legislation is designed to keep down inter-union strife. Admittedly, before the employees of an institution have chosen a bargaining agent the hospital may find more than one union competing for all or part of its employees. But once a union has been certified no other union can compete for the employees in that group for a certain length of time after the certification—generally 10 months—or for 10 months after an agreement has been concluded. Then there will be an open season for two months after which the embargo comes into effect for another 10 months. This describes the situation in very general terms only, but the principle is easy to grasp: a certificate and/or an agreement brings freedom from inter-union rivalries for fixed periods as prescribed by statute. The importance of this from the point of view of both personnel and the administration should be obvious. There is nothing more likely to create unrest and poor job performance than continuous strife between rival unions.

Of equal importance, perhaps, is the fact that, except in Saskatchewan, the agreement with the union must, as was shown earlier, provide for a peaceful settlement of grievances arising out of its operation. A good grievance procedure is one of the most effective ways of keeping personnel contented and therefore better able to perform their various tasks. It means that employees are no longer required to take up their grievances personally with those in authority, something which employees are often loathe or frightened to do. With a good grievance procedure in effect the employee will now speak to his union representative. He knows that if he has a real grievance it will be dealt with forcefully and fairly and if it is fanciful the union will probably tell him he has no case. This makes for good personnel relations because most grievances will be brought out into the open and solved before they can reach the serious stage.

Strikes

When a union moves into a hospital probably the greatest worry of hospital management is the thought of strike action. It should be made clear at the outset that this fear is completely ungrounded. There have of course been strikes in hospitals, particularly in the United States. The chief cause of these strikes, however, was the refusal by the hospital to recognize and bargain with a union. This state of affairs cannot arise in Canada because as has been shown once a union is certified as a bargaining agent the hospital is bound to bargain with it in good faith. The question of union recognition is no longer a controversial issue.

The only time a lawful strike can take place is during the bargaining stage either for a first agreement or for the renewal or revision of the agreement. Except in Saskatchewan, once an agreement is reached lawful strikes cannot take place during its operation. In Saskatchewan strike action is permissible after the signing of a collective agreement. In a few jurisdictions strikes against hospitals are completely outlawed even during the bargaining for an agreement. This is the situation in Minnesota in the case of a dispute over maximum hours of work or minimum hourly wage rates and it is true of Quebec for all issues in dispute. In these circumstances compulsory arbitration must be resorted to and the findings of the arbitrator are binding on the parties to the dispute.

It will be apparent from what has just been said that while the law has curtailed the occasions on which strike action may be taken, it has not, except in a few instances, forbidden it completely. Whether this weapon will be used against hospitals depends to some extent on the sense of responsibility shown by the unions. In the main, they are quite responsible. The unions have had considerable experience in this field and realize how serious a proposition they have on their hands in the case of a strike against a hospital. They realize that the hospital would have public sympathy on its side and that it could call on many volunteer agencies and public spirited citizens to lend a hand. Consequently most of the unions are prepared to insert a no-strike clause into the first agreement. While this does not prevent a strike in the negotiation of the first contract it does mean that once the agreement is signed the union agrees that it will not strike when it comes up for renewal or revision.

Thus the only occasion on which a strike is likely to occur against a hospital is during the bargaining for the first agreement. But because the chief cause of strikes on this occasion—re-

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Note: Action of air injector can be demonstrated as follows: Start Inhalator in operation and when vapor is being projected from nozzle, wrap a handkerchief or other material over the four holes in tube just above handle. This cuts off air supply and steam coming out of nozzle will not be projected. Remove handkerchief and notice how vapor is again projected.

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Ceremonies Preliminary to Construction of New A.H.A. Headquarters

Ground-breaking ceremonies were held in Chicago on November 9th for the 17-storey American Hospital Association headquarters and centre for hospital affairs. The building will be constructed on a site made available by Northwestern University.

Pictured above, Ray E. Brown waits his turn as President J. Roscoe Miller of Northwestern University signs the lease for the site. Standing by are, left to right: Dr. H. M. Coon, AHA trustee and superintendent of University Hospitals, Madison, Wis.; Dr. Frank R. Bradley, immediate past president of the AHA, and director of Barnes Hospital, St. Louis, Mo.; Joseph G. Norby, Milwaukee, AHA past president and member of the Committee on Headquarters Building; Maurice J. Norby, deputy director of the American Hospital Association; John N. Hatfield, chairman of the AHA's Committee on Headquarters Building and director, Passavant Memorial Hospital, Chicago, Ill.; Rt. Rev. John W. Barrett, director of Catholic Hospitals, Archdiocese of Chicago; and Dr. Edwin L. Crosby, director of the A.H.A.

Unions Come to Hospitals

(Continued from page 68)

fusal to recognize the union—has been eliminated and, having regard to the fact that unions from past experience are fully aware of the seriousness of strikes against hospitals, it is highly unlikely that strike action will follow even at this stage except in isolated cases where, in all probability, the hospital management will be equally at fault in the matter.

To some extent this was probably the case in Minneapolis in 1951 when the employees of 10 hospitals went on strike. This was a rather nasty affair involving some violence on the picket line, resorts to the courts and a subsequent refusal by six of the hospitals to re-hire employees. It is most interesting to note that in the twin city of St. Paul, the hospitals and the union were able to settle their differences amicably although the same issues were involved.

Some Suggestions

At this point a few suggestions may not be out of line. In the first place do not be fearful of the unions but, on the other hand, do not underestimate the people representing them. By and large they are, to-day, a well-trained group. They are intelligent and many of them are well-educated. They know their jobs. This means that the representatives of hospital management must be well-prepared when they meet the union representatives around the bargaining table. Hospitals will find themselves outsmarted and occasionally even exploited unless they have their facts and figures at their fingertips. It is useless having last month's statistics if the union has this month's.

Bargaining is a process of give and take. To know how much to give and when to seize the opportunity of taking is an art requiring experience and knowledge. The unions will usually have the knowledge and the experience. They will understand when it is in their interest to pound the table, when it pays to be persuasive and when it is sufficient to let the facts speak for themselves. In going to meet the union's representatives hospitals should: (1) make certain they have the latest information on wages and other working conditions in their localities; (2) try to ensure that least one of their representatives has had some experience in the field of collective bargaining; (3) plan before hand not only the concessions they are prepared to make but those they want from the unions. Hospitals must realize that bargaining with a union is not simply a question of giving. After all the agreement defines the relations of the parties to it and must set out the rights of *both* parties as well as their obligations and duties.

Because smaller institutions may not have the facilities necessary for proper preparation for collective bargaining, it is suggested that hospital associations and institutes give serious consideration to setting up some sort of clearing house for the collection and distribution of sample collective agreements and general information with respect

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Unions Come to Hospitals

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to collective bargaining in hospitals. This might be done on the municipal, provincial or even the national level. However, if completed, it would be of great value to institutions facing unions for the first time and even to those with past experience.

Another matter which unorganized hospitals (except those in Quebec) might well consider is this. If it is clear that a union represents a majority of the employees and the union representatives appear to be reasonably responsible, some thought should be given to voluntary recognition of the union and to collective bargaining with it, without forcing the union to apply to the Labour Board for certification. By so doing the hospital does not lose any of the benefits or protection of the legislation. And by so doing the hospital will increase its stature in the eyes of the union and of its employees and so place itself in a better position to negotiate concessions. Too few employers today are willing to do this; there is still a tendency on the part of management to resist to the bitter end. This does not make for good labour relations and, after all, that is the object of both sides. It is not suggested that if voluntary recognition is given, everything will be plain sailing from then on. Hospitals, like other employers, are going to have their troubles at times. Tempers will probably be ruffled and uncharitable things said, or at least thought, about the people on the other side of the table. But a little charity here and there can work wonders.

There are many topics and problems such as union shop provisions, the Rand formula, and suspension of bargaining rights, which it has not been possible to cover in this article. The object has been to give a broad picture of what it means to have unions in hospitals so that management will have some idea of what to expect and of how to prepare for the problems which are bound to arise.

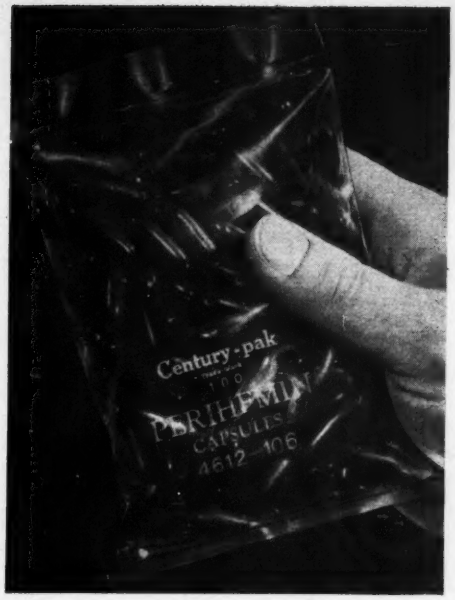
Health Week

This year Canada's 12th National Health Week, sponsored by the Health League of Canada in co-operation with departments of health and education from coast to coast, will take place from January 29 to February 4. Health Week brings to the attention of every Canadian the fact that health is of great national importance to everyone in the country—the message that prevention is better than cure, and that "The greatest wealth is health".

American College of Surgeons to Hold Sectional Meeting

More than 3,000 surgeons, surgical specialists, nurses, and other medical personnel from Canada and the United States are expected to attend an intensive, four-day sectional meeting of the American College of Surgeons in Philadelphia, Pa., February 13-16, at the Hotel Bellevue-Stratford. Dr. Calvin M. Smyth, Jr., Philadelphia, is chairman of the Local Advisory Committee on Arrangements.

In length and scope this meeting will approach that of the annual clinical congress. Sessions in general surgery and the specialties, hospital clinics, surgical forum research reports, cine clinic films, will be included.



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On-Service Education

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bers are enabled to help in policy formation, in committee work, and in research. This is time-consuming but helps tremendously to ensure the effective utilization of the human resources of the organization. Time and again it is demonstrated that many heads are better than one and that group effort is productive of maximum results. Another important factor is an active program of supervision and evaluation of personnel.

The aims of the staff education program are best realized when the environment of the organization is a permissive one in which individuals can exercise their particular capabilities, develop their full potentialities, and recognize the worth of their contribution to the work of the whole. The administrative officers of the institution, by their democratic philosophy of management, their appreciation of the factors which promote the growth of individuals, their maintenance of good personnel policies, and their provision of facilities and opportunities for staff education, have a major influence upon the extent to which the program will flourish and produce results in terms of satisfied employees and improved service to patients.

"Routine Examination"

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impressed on medical staffs and all concerned.

Summary

Hospital authorities and medical staffs have an obligation to their patients to keep the costs of hospital care as low as possible in accordance with current medical and hospital standards. It is suggested that a worthwhile field of endeavour in this respect is to conduct a critical analysis of the extent of utilization of the word "routine" by the medical staff when referring specimens to the laboratory for examination.

It is suggested that the analysis will disclose, in many hospitals, that the laboratory is performing, in accordance with the order "For Routine Examination", many tests on many specimens which are of very limited value to the patient, while, on the other hand, they add considerably to hospital and patient costs.

Evaluation of the use of the word routine in connection with the referral of laboratory specimens and restriction of its application may, in many institutions, prove a fertile field of endeavour in an effort to reduce patient and hospital costs.

New Korean Hospital

Recently opened in Mapo, Korea, was the Han-No Children's Tuberculosis Hospital — a 30-bed institution set up by the Norwegian-Korean Association with the help of the city of Seoul, the United Nations Korean Reconstruction Agency, and other organizations. The hospital receives tubercular orphans and operates in conjunction with the Seoul City Children's Hospital. The building, formerly a Japanese dispensary, was donated by the city of Seoul; UNKRA provided $5,000 for renovation; and other agencies furnished part of the building materials and medical supplies.

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Co-operation Essential

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was carried out by Michigan State Medical Society and Michigan Blue Cross. In this connection, Dr. Harry F. Becker states: "This study tends to prove that in Michigan—and I have no doubt that the same holds true with minor variations elsewhere—over 28 per cent of all hospital admissions contained some element of faulty use. As one would expect, these 'faulty' admissions, were, of course, more frequent among 'insured' patients . . . Nearly one out of five days used by Blue Cross patients was not a necessary day."* This is very interesting, particularly in light of the fact that the American Hospital Association reports the average length of stay in Michigan to be 7.4 days. In B.C. the average length of stay is 10.4.

I mention these points to illustrate the reasons why the government of British Columbia feels alarm, and why we are doing all we can to keep our hospital insurance plan operating on a reasonable basis. In this, I ask for your continued support. With few exceptions, I can state that the past associations with you individually have been most co-operative and all I ask is that this is continued.

I believe we can look forward to the coming years with optimism, particularly since the people of British Columbia have indicated their desire for adequate hospital accommodation. Next year will see a peak in the construction of hospital facilities for acute care since some $22,000,000 worth of hospital projects will be in various stages of development. At the same time, planning for chronic facilities is advancing apace and I am quite confident that we will see several projects become realities soon.

With an expanding population comes the need for essential services such as these, and I have every reason to believe that our requirements will be fulfilled in this regard.

Trustees

I have nothing but the greatest admiration for the work done by the members of the hospital boards throughout the province. There are times when they must feel very discouraged because of happenings beyond their control which tend to create what may seem to be, at the time, insurmountable difficulties. It is a pity that the community in general does not show more sign of appreciation for the great work done by the members of these boards who, it must be remembered, volunteer their time and effort in the furtherance of essential hospital facilities. The work of a hospital board is of tremendous importance and no matter what difficulties may arise, patience and perseverance will always overcome them. I pay tribute to those public-spirited people who devote so much of their personal time to the management of the hospitals of British Columbia.

*See "Hospitals", December 1954, page 12.

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Princess Margaret Hospital

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A drive for funds to assist in the construction of a tuberculosis hospital netted £50,000, the target figure, in 1953; and it will be constructed on a site adjacent to the general hospital. It is being erected in memory of the late King George VI. In 1955 the government of the Bahamas voted £230,000 for the construction of a 200-bed mental hospital and an infirmary for old people on two separate sites. It is expected that the new mental hospital will be completed by midsummer of this year. These two institutions will replace older and inadequate buildings. The estimate does not include quarters for staff. There is also a small leprosarium with an average of 12 patients who occupy themselves by working in a small but very rich citrus orchard.

These then are the hospitals which serve the population of the Bahamas, approximately 87,000 persons. District medical officers are stationed on the larger Out Islands and 20 nurses and 12 midwives are in the Out Island service. Charter flights by Bahamas Airways Limited bring emergency cases to The Princess Margaret Hospital and in each case the patient is accompanied by a medical officer or qualified nurse. The planes, being amphibian, can be landed almost anywhere in the area. Pilots take off at the shortest notice and in almost any weather, a service which has saved many lives.—*J.F.*

For Trustees Only

(Concluded from page 49)

most successful things we did was to hold a series of card parties. This was worked out by attempting to have everyone in the town make up groups of four couples who would hold a card party once a week in each of their homes, with a charge of 25c or 50c per person each night they played. After meeting in each home, the winners of each group met in a final play-off for prizes. With a few hundred people joining in on something like this, you can figure for yourself what the returns would be.

This then, is the story of our fund-raising campaign which resulted in sufficient funds to pay for everything. However, let me stress two points. First—there is no substitute for a personal canvass, and second—be sure that the complete hospital story is told to everyone, and keep on telling it and telling it until you have finished the job.

Twenty Years Ago

(Concluded from page 20)

the provincial government as an unemployment work "to take precedence" over all other projects of a relief nature.

Quietly and without any ceremony, the new Women's College Hospital on Grosvenor street, Toronto, was opened on December 16th. Twenty patients were transferred from the Rusholme Road Hospital, which the new structure replaces.

E. W. Neel, chairman of the King's Daughters Hospital board, Duncan, B.C., was re-elected president of the British Columbia Hospitals' Association at the annual convention in Victoria on November 20th.

You can start or stop fluid flow and adjust its rate as many times as necessary with the exclusive Cutter Safticlamp*... and *one* hand does all the work.

The Safticlamp, built into every Cutter expendable I.V. set at no extra cost, is practical, too. It can't get lost or misplaced, can't slip, break or damage tubing. And you can actually bend the Safticlamp *up to 130 times* and still have positive flow control.

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Study of Cancer Incidence

Most types of cancer show a greater incidence among men than women, which may result from a different degree of exposure to environmental factors, according to data from ten metropolitan areas studied by the National Cancer Institute of the Public Health Service, U.S. Department of Health, Education, and Welfare. The difference in the incidence rates increases with age, especially for respiratory cancer, leukemia, and cancer of the buccal cavity. This suggests a difference between men and women in terms of the intensity or amount of exposure to certain factors, such as occupational hazards and social habits. Only cancer of the breast, reproductive organs, and certain endocrine glands was found to occur more frequently among women than among men.

These and other significant findings are reported in a monograph published by the Public Health Service which presents the first of a two-part detailed summary and interpretation of the ten integrated cancer illness studies. The publication is entitled "Morbidity from Cancer in the United States — Variation in Incidence by Age, Sex, Race, Marital Status, and Geography." The authors are Dr. Harold F. Dorn, Chief, Office of Biometry, National Institutes of Health; and Sidney J. Cutler, Statistician, National Cancer Institute. It is available from the Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 65 cents a copy.

The work represents a statistical analysis of thousands of cancer cases examined in ten large population centres which were surveyed in 1937-39 and resurveyed ten years later. The areas are: Atlanta, Ga., Birmingham, Ala., Dallas, Texas, New Orleans, La., San Francisco, Cal., Denver, Col., Chicago, Ill., Detroit, Mich., Philadelphia, Penn. and Pittsburgh, Penn.

Commenting on the sex variation in cancer incidence reported in the monograph, Dr. John R. Heller, Director of the National Cancer Institute, observed that the risk of developing cancer is 60 per cent greater for men than for women if genital and breast cancer are excluded. "This greater risk is related, in part, to the survey findings that cancer of the lung and bronchus occurs more than five times as frequently, and laryngeal cancer twelve times as frequently in men as in women," he said.

The data further indicate that the death rate from cancer is now definitely higher for men than for women in the white population. This reversal of the relative standing of the sexes which had existed for whites until a few years ago is also expected to occur soon in the non-white population, in which the margin of female deaths over male is rapidly narrowing.

The report notes a positive correlation between cancer incidence and chronological age — the older the person the greater the likelihood of cancer. Half the people with diagnosed cancer, both men and women, were between 50 and 70 years of age. But great variations were found between men and women in the relative occurrence of cancer of different parts of the body and age at which the disease manifested itself. Men appear more susceptible to cancer than women in the first two and the last

two or three decades of the usual lifetime, whereas women have a higher rate during the childbearing years. In fact, at about age 35, relatively twice as many women as men are found to have a malignant tumor. After the childbearing period, however, the male rate catches up with and exceeds the female rate.

In women, nearly half of all cancers originate in the reproductive organs and nearly one-fourth in the digestive system. Among men, the reproductive organs account for only one in eight cancers, while one-third originate in the digestive system — *U.S. Department of Health, Education, and Welfare.*

Kill that Cockroach

That repulsive creature which may haunt your hospital, the lowly cockroach, can be a more dangerous enemy than you suspect. Recent studies show the cockroach is probably responsible for many of the diseases blamed on rats, mice, and house flies.

The same kind of insect you bring into your institution in a grocery bag is the carrier of a dangerous tribe of germs called Salmonella. Salmonella, when it infects a human being, can produce meningitis, serious fever similar to typhoid, complicated local infections and acute gastroenteritis, which is common food poisoning, the most frequent result of Salmonella infection. Food poisoning by the Salmonella is most serious among babies and young children, where the death rate is high. But even among adults it can cause a great deal of pain and weakness, and in this group the death rate reaches one in 100.

People are generally infected by eating foods which contain Salmonella germs. Since cooking usually kills these bacteria, most people become infected from foods contaminated by the germs after they have been cooked. And that is where the cockroach enters the picture. Tests by Professor Theodore Olson of the University of Minnesota showed that roaches can harbor these Salmonella germs outside their bodies up to 78 days.

Because a cockroach can penetrate almost any nook or cranny, including closed refrigerators, if he's infected he has plenty of time to contaminate food merely by walking across it. If he tarries a while to eat, and he invariably does, he can hardly miss. Even after an infected roach is dead, the Salmonella germ will live. It can pack a poisonous punch after 34 days on bare glass, stay potent for 62 days on cornflakes and last for three months on soda crackers.

These research findings do not mean that all cockroaches are infected, but knowing they can carry disease, the smart thing to do is to put them in the same category as rats and mice. Kill them. They can be more dangerous in the kitchen than you think. — *Mississippi Blue Cross Bulletin.*

Food Service Contest

An opportunity to demonstrate that your food service facilities are among the finest in the field is offered all operators of mass feeding establishments in the 10th Food Service Contest sponsored by *Institutions Magazine.*

The contest is now underway and will close February 15, 1956. Complete information can be obtained by writing: Food Service Contest Editor, *Institutions Magazine,* 1801 S. Prairie, Chicago 16, Ill.

Community Baby Gains Weight

THE PNEUMATIC drills are quiet for the moment, as activity centres round the contractor's hut. The girl at the switchboard relaxes, and in the momentary lull the calls come through clearly. She turns the buzzer down. "Old Mrs. Dexter's condition?" "What word on the highway accident emergency cases?" "How soon can a new grandmother visit?"

The girl at the dictaphone nearest to the scene of building operations runs a hand through damp curls, then realizing a welcome silence from interference, types with enthusiasm; ". . . the meeting then adjourned."

Down below, it's cooler, but not much. Walls lately cut through show new corridors extending in shadowy length to the wards and departments they will shortly serve. Vague forms pass and re-pass in the dimness of the outer structure. A gleam of white plaster shows in the far distance, as workmen trundle down runways with further bags.

The patient waiting for a blood test stops mopping his forehead. "Getting on with the job," he comments with satisfaction to the man in the ankle cast seated beside him. "Time, too," says the other man: "Built only five years, already bursting at the seams."

Administration is very active. Time is getting short, assistants must be selected for those in key positions, extra staff readied and on hand for the big push. At the same time, a combination of heat and noise may provoke a situation calling for tact and arbitration. The personnel manager runs his hand under a wilting collar—luckily his wife put an extra shirt in his car, interviews with applicants may keep him late tonight.

The Director of Nursing, at her desk for a brief moment, raises her eyes to the window. The fields she played in as a child are now covered as far as she can see by the hospital and the new extension which will double its size. She feels a personal thrill. Many of the patients are old friends, board members and doctors in off duty moments are Bill and Jack. She'll stand the noise of the drills all right—it won't be long now.

The campaign secretary puts her head in the door: "What do you know? The employees of the brick works have kicked in fifteen hundred," she announces jubilantly.

Prowling around the ramparts like look-outs of bygone years go members of the Board and Building & Equipment. Meetings go on far, far into the hot night, but these people will stand the heat and noise all right,—it's their baby.

More than that, it's Our Town's baby. The drills are silent, lights are twinkling as the night watchman takes over in the construction hut. Men are coming home from the factories and mills where accidents happen so quickly, along highways where trouble may lurk at any corner. Jane Doe, whose tonsils were removed on her mother's kitchen table, tucks her children in bed and feels comfort and security in the black outlines rising against the sky.

Our community baby is growing up.
—*M. M. Leeper.*

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Canadian Council of Blue Cross Plans Meets

At the annual meeting of the Canadian Council of Blue Cross Plans, held at the Royal York Hotel, Toronto, from Nov. 25-27, it was revealed that the five Canadian plans now protect approximately 3,500,000 citizens — a net increase of about 200,000 since December 31, 1954. A large percentage of this enrolment is through employed groups in some 23,000 firms.

One of the contributing factors in the growth of participation in Blue Cross was the introduction of the National Group Contract a year ago, which makes it possible for Canadian employers, who have employees across the country, to secure uniform benefits at uniform rates. In an endeavour to provide the maximum in service, benefits and rates for this contract, extensive research and planning is still progressing under the direction of the council. As a result of this study, the co-ordinating body approved the opening of a national office in Toronto to act on behalf of all Canadian Blue Cross Plans. Many phases of Blue Cross activities on a national basis were discussed, including enrolment, public relations, office practice, and hospital claims and relations.

The central co-ordinating agency for all Blue Cross Plans in Canada, the United States, and Puerto Rico is the Blue Cross Commission of the American Hospital Association, and the five Canadian plans actively co-operate with the Commission. Annual approval is granted by the Commission to those plans meeting certain high standards of sponsorship, administration, and enrolment growth.

The five Blue Cross Plans of Canada, which form District XII of the Blue Cross Commission, are organized as the Canadian Council of Blue Cross Plans. This body acts on matters pertaining to the over-all Canadian Blue Cross picture. The Council has a voluntary governing board on which all plans are represented, an administration section made up of the executive director from each plan, and subcommittees on office practice, enrolment, public relations, and hospital claims. The Canadian Council of Blue Cross Plans appoints a commissioner to the Blue Cross Commission.

Officers

President: Judge N. V. Buchanan, Edmonton, Alberta Blue Cross Plan.
Vice-president: J. A. Likely, Charlottetown, Maritime Hospital Service Association.
Secretary-treasurer: J. A. Monaghan, Edmonton, Alberta Blue Cross Plan.
Chairmen of Executive Committee. D. W. Ogilvie, Toronto, Ontario Blue Cross Plan, and E. D. Millican, Montreal, Quebec Hospital Service Association.
Commissioner for Canada: F. D. MacCharles, Winnipeg, Manitoba Hospital Service Association. (Mr. MacCharles will succeed Ruth C. Wilson, executive director of the Maritime Hospital Service Association, as Commissioner for Canada at the annual conference of Blue Cross Plans in April.

PSI Increases Rates

Higher fees for medical coverage will go into effect this month under Physicians' Services Inc., (Ontario) it was announced recently. The increases will range from five cents to $1.25 per month. According to Dr. R. M. Anderson, president of P.S.I., the raise in fees has been necessitated by higher doctors' fees, greater use of services by subscribers anl their dependents, and partial depletion of the organization's reserves.

Auxiliaries

(Concluded from page 60)

to discuss the organization of an auxiliary to Providence Hospital. A committee to draft a constitution was also appointed. Providence Hospital has been in existence since 1913.

* * * *

Lectures and Tours

A series of lectures on health education began last November at the New Mount Sinai Hospital, Toronto, under the auspices of the Women's Auxiliary. The purpose of the series is to provide a better understanding of the mental and physical forces which affect our well being. Each lecture is followed by a conducted tour of the hospital.

* * * *

New Auxiliary Organized

An auxiliary to the Queensway General Hospital, Toronto, was organized in December when representatives of the ten districts which the hospital will serve met to draft a constitution. The hospital, now under construction, is scheduled to open in the spring.

* * * *

Country Fair Big Success

The annual Country Fair staged by the auxiliary to Royal Columbian Hospital, New Westminster, B.C., netted about $5,000 for the hospital last November. Among items supplied by proceeds from the annual "do" are equipment for the nursery, and a Christmas gift for each patient in hospital on Christmas day. The auxiliary has also provided nurses at the Royal Columbian with a cottage for their use in the summer.

* * * *

Cooking School Popular

Among the fall projects sponsored by the Women's Auxiliary to Victoria Hospital, London, Ont., was a three-day cooking school. Visitors to the school not only gleaned a great deal of information, but also had the chance of winning a number of substantial prizes, including a gas range donated by a local company.

* * * *

Fun Fair Nets $1800

Over $1,800 was realized from a Fun Fair sponsored by the Ladies' Auxiliary to Morden District General Hospital, Morden, Man. Movies for the youngsters and a fish pond were popular at the fair, while a cedar hope chest was among the many prizes given.

NEW, COMPLETE LILY SERVICE

Revolutionizes Hospital Catering...

Matched for BEAUTY!

Another Lily ADVANCE

Plastic-Coated PLATES

Another Lily feature, invaluable to hospital catering, is this outstanding line of plastic-coated paper plates. Completely non-absorbent, these first-quality plates just can't soak up gravies, or salad dressings. Supplied in 6", 7", 8", 9", 9⅝" sizes in attractive green leaf design. Uncoated plates for cold foods also available in these sizes.

...FOR FIVE VITAL REASONS

- **Economical** — no breakages, no dish-washing.
- **Hygienic** — safeguard against cross-contamination.
- **Labour-Saving** — lightweight for nurses.
- **Quiet** — no clatter to disturb patient.
- **Attractive** — gay, cheerful "matched for beauty" green leaf design.

NOW, with Lily's new paper matched Single Service complete meals are available to hospitals in a compact, highly economical form. Economical, because Lily means an end to breakages and a reduction in staff because there's no more dish-washing. The Lily service is popular with doctors since it provides a sure safeguard against cross-contamination. And nurses go for Lily tray sets—they're so light and easy to handle. Patients, too, enjoy the cheerful green leaf design, and the absence of disturbing clatter. Yes, Lily's matched service brings a striking new advance to hospital catering.

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Mechanized Self-Indulgence

(The following is from a paper by Wilder Penfield, O.M., M.D., in "Canadian Services Medical Journal", October, 1955.)

This is a mechanized age in which we live. Of recent years it would seem that man's wit had outstripped his wisdom and that research might have gone too far for the common good. Some would wish perhaps that no automobile could be made capable of exceeding the speed of safety. Many have wished that the terrible secret of atomic destruction had never been discovered.

But Pandora's box has been opened. It is useless to wish it closed and the spirits of evil to be imprisoned there again. As I remember the myth, the last of the spirits to escape was Hope. And there is hope now that with science pressing onward to seek the light of understanding, all these things will somehow lead to greater good.

The automobile like the atomic bomb must be controlled. If we cannot do so we may as well crawl back into the caves from which, it is said, we came. Indeed, if we do not there may eventually be no place else to go.

The world's problem does not lie in the discoveries of physicist or engineer. The problem is man's behaviour in this mechanized age. So many have turned from a simple way of life to mechanized self-indulgence leaving their undisciplined children, shall we say, to the tender mercy of television and the gospel of the comic strip.

Coming Conventions

May 29-31—Maritime Hospital Association Convention, Algonquin Hotel, St. Andrews, N.B.

June 9-10—Catholic Hospital Conference of British Columbia, Vancouver.

June 11-15—Western Canada Institute, University of British Columbia, Vancouver, B.C.

June 11-15—Canadian Medical Association, Ecole de Commerce, Quebec City, P.Q.

June 16—British Columbia Hospitals' Association, University of British Columbia, Vancouver, B.C.

June 25-29—Biennial Meeting of the Canadian Nurses' Association, University of Manitoba, Winnipeg, Man.

June 26-28—Canadian Dietetic Association, Macdonald Hotel, Edmonton, Alta.

Sept. 17-20—American Hospital Association Convention, Chicago, Ill.

Oct. 16-18—Associated Hospitals of Alberta, Macdonald Hotel, Edmonton.

Oct. 22-24—Ontario Hospital Association, Royal York Hotel, Toronto, Ont.

Oct. 24-26—Saskatchewan Hospital Association, Bessborough Hotel, Saskatoon, Sask.

Oct. 30-Nov. 1—Manitoba Hospital and Nursing Conference, Winnipeg, Man.

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ABBO-VAC(R)–A-C-D Solution, U.S.P. (N.I.H. Formula B), in Universal bottles, 500- and 250-cc. sizes. Blood is drawn directly into container by vacuum. Sterile, disposable Blood Donor Set also available.

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NON-VAC* – A-C-D Solution, U.S.P. (N.I.H. Formula B), in Universal bottles, 500- and 250-cc. sizes. Blood is drawn directly into container (closed technique) by gravity. Donopak(R) 24 and 48, with or without attached, sterile, disposable needles also available.

Abbott A-C-D Blood Container – A-C-D Solution, U.S.P. (N.I.H. Formula B), in the familiar Abbo-Liter(R) intravenous bottles, 500- and 250-cc. sizes. Blood is drawn (closed technique) directly into container by gravity. Available with Sodium Citrate 3% Solution in 500-cc. size. Donopak 24 and 48, with or without disposable needles also available.

For Storing Plasma:

Evacuated Empty Plasma Containers – Sterile evacuated 500- and 250-cc. Universal bottles for storing, transporting and administering plasma or serum.

ADMINISTERING BLOOD and/or SOLUTIONS

Blood Recipient Set–Sterile, disposable, ready-to-use plug-in set for administering blood from any Universal bottle or Abbo-Liter type bottle. Has flexible plastic filter chamber.

VENOPAK(R)– Abbott's sterile, disposable venoclysis unit for the administration of all intravenous solutions. Converts readily to a blood recipient set with a special, disposable blood filter. For use exclusively with Abbo-Liter(R) containers.

(Series Hookup)

Secondary Recipient Set – A unique, disposable unit with a built-in, flexible drip chamber and filter. Designed to plug into any Universal blood bottle and to connect with Abbott's VENOPAK dispensing cap. Allows changeover from saline to blood in a matter of moments, without removing needle from vein.

Secondary VENOPAK – Disposable unit designed for the continuous administration of fluids in the series hookup with VENOPAK.

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SUB-Q-PAK(R)–A completely disposable, preassembled hypodermoclysis unit with plastic Y tube for administration of fluids subcutaneously.

ADMINISTERING PENTOTHAL(R)– SODIUM

VENOTUBE(R)– Length of plastic tubing with attached male and female Luer adapters and pinch clamp. Allows anesthesiologist to keep syringe off the patient's arm. Pinch clamp offers additional factor of safety.

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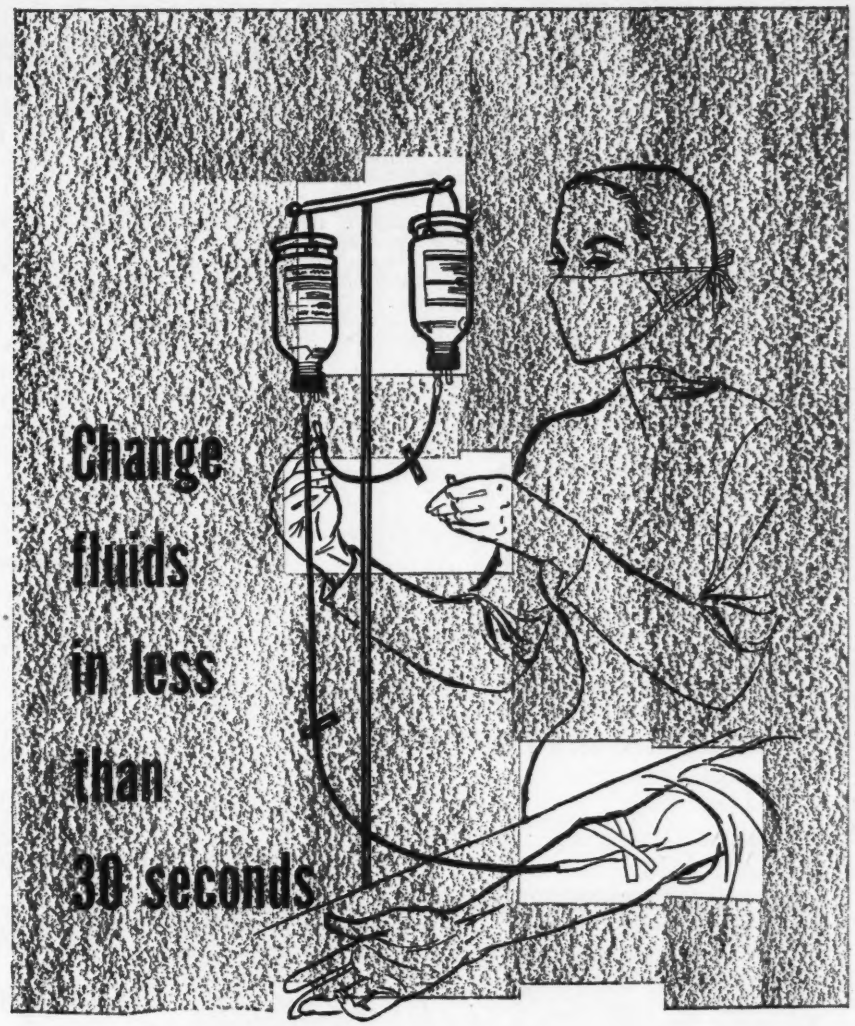

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To Make Your Linens Last

For sheets to last, give them plenty of rest. Of all suggestions for linen longevity this is the most often repeated. Every textile expert suggests sheets and pillowcases be allowed a day or two off between each laundering to allow the fibres to dry thoroughly.

See that repairs are made at first sign of wear or tear. A few stitches around a hole will stop fraying and prolong life. If wear is perceptible in part of a sheet, see that the part is not in the area of greater wear when the sheet is replaced on bed. That area is around the hips.

Never yank sheets but loosen their edges and remove them gently.

Check beds for sharp edges. Use gummed paper or adhesive tape on them and cover bare springs with heavy cloth or sheeting.

Train maids in correct procedure in case of stains. Let the laundry know what caused a stain where possible. A good quality sheet, well cared for, should last at least 200 washings. A pillowcase, 150 washings.—*Canadian Hotel Review and Restaurant, January 15, 1955.*

Position Wanted

Accountant-office manager, experience in 85-bed hospital, requires position in hospital of similar or larger size: Apply Box 1013M, The Canadian Hospital, 57 Bloor St. West, Toronto, Ontario.

Dietitian Wanted

Dietitian wanted for 105 bed hospital. Full maintenance provided if desired. Apply stating qualifications to Matron, Red Deer Municipal Hospital, Red Deer, Alberta.

Accountant Required

Experienced hospital accountant required immediately to take complete charge of business office. Reply giving personal data, experience and salary range to Superintendent, Brockville General Hospital, Brockville, Ontario.

Business Administrator

Business administrator wanted for 166 bed hospital for tuberculosis. Please reply stating age, qualifications, experience and salary expected to Mr. F. W. Sheridan. Chairman, Personnel Committee, Sudbury-Algoma Sanatorium, P.O. Box 40, Sudbury, Ont.

German Nurse Available

German government approved nurse, age 21, good education, fair English knowledge, healthy and diligent, desires suitable work in hospital (operation room or chirurgical dept. preferred) Paula Schwankhart, Stadtkrankenhaus, Ingolstadt, Bavaria, Germany.

X-Ray Equipment For Sale

Stanford consultation. X-Ray Stereoscope. Type c-36 (202) New Mirrors. Incandescent lighting. Best Offer Accepted. Calgary General Hospital, Calgary, Alberta.

Qualified Dietitian Wanted

For 550-bed teaching hospital, opened January, 1955. Apply to Director of Dietetics, University Hospital, Saskatoon, Sask.

Administrative Personnel Placement Service

Mary A. Johnson Associates welcomes inquiries from Hospital Trustees and Administrators for assistance in locating Administrative and Department Head Level Personnel for Hospital and Medical Group positions.

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Our files contain many well qualified personnel as well as interesting openings.

We pride ourselves on careful screening of all our clients and thorough investigation of openings. Our aim: to match the applicant and the specific position.

All inquiries strictly confidential

MARY A. JOHNSON ASSOCIATES

11 West 42 Street, New York 36, N.Y.,
Mary A. Johnson, Ph.D., Director

Planned Spending

(Concluded from page 48)

other utilities are budgeted for, these budgets are prepared in the Accounting Department from the previous year's experience and are not left to the department head to estimate. Estimates for steam are based on floor space, for electricity on the wattage count in each department, on special maintenance by the actual amount of work orders involved in the previous year, plus any knowledge available as to new renovations proposed.

Reports to the Board

The Board of Trustees becomes keenly interested in the operation of a budget and this information is submitted along with the financial statements. Such submissions usually show comparisons between actual expenditure and budgeted expenditure analysed under the main headings of salaries, supplies and "other" expenses for the period under review.

The budget for income is based on the previous year's occupancy experience taking into consideration any new rates established during the year or changes in method of operation. In reporting on income budget, the chief headings used are Room Charges, Special Services, O.P.D., Emergency, Provincial Government, and other Grants estimated.

We hope the above will be of some value to those who are interested in advance estimates and, while an article of this brief nature cannot be considered as a text book, the use of the *Canadian Hospital Accounting Manual*, plus the co-operation of division heads, plus the application of general common sense, will enable any hospital to make a budget workable. A book could be written on the various ramifications that come up during the year as to analysing and determining the proper slot in which to place various types of expenses. The size of the hospital would have an important bearing on the extent of the detail which should be set up; although it is found that even with the present detailed methods in use in the Hospital for Sick Children there are many queries that arise as well as requests for more extensive information. The Superintendent must measure the value of detailed data against the cost of procuring it.

Toronto Building Apartments for Aged

Toronto is again expanding its facilities for the care of the city's aged persons. Construction began in November on a low-rental housing project consisting of eight apartment buildings. Each building is to contain 16 suites, which will rent at $40 monthly. The project, which will cost about $700,000, is scheduled for completion early this year.

Half of the apartments will be one-bedroom units and the rest will be bachelor suites consisting of a bed-sitting room and kitchen.

Plans have also been approved for a similar project, part of a $15,000,000 development program sponsored jointly by Toronto and provincial authorities. A 525-bed home for the aged now under construction by the city will provide beds for older persons needing special care.

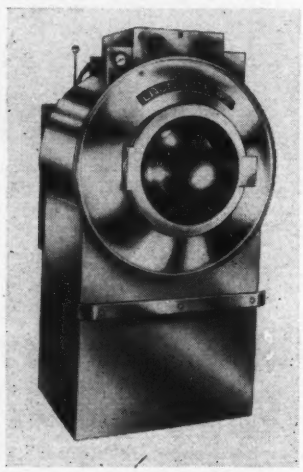
News Released by Hospital Supply Houses

By C.A.E.

Automatic Washer

An additional "Laundrite" washer model of 40 to 45 pounds capacity has been announced by Troy Laundry Machinery Division.

Referred to as the Laundrite "40", the new machine was designed with automatic operation similar to the popular 25-pound model, but has this greater capacity. Accordingly, it is reported, the "40" fits that spot in the laundry where a washer of 40 to 45 pounds capacity can best meet requirements of volume, type of work, schedules and space available.



"Laundrite" Washer

Full range temperature control is provided through a selective thermostatic dial setting. Controls also provide automatic water level and cycle timing as well as dumping. Yet the controls allow any change, at any time, by a turn of the dial.

On request, a free bulletin will be sent by McKague Chemical Co. Limited, Ontario distributors.

Single Unit Power Cleaning

The "Vacmobile", distributed in Canada by Dustbane Products Limited, Ottawa, Ont., is made to provide large

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and small establishments with power cleaning in the form of a single unit that cleans, scrubs, dries, dusts and polishes.

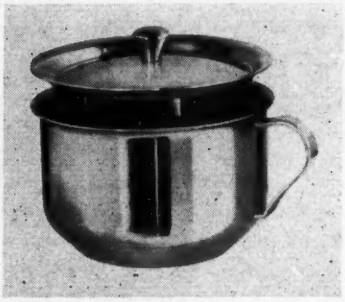
It rolls over sills and carpets, climbs ramps and stairs, rolls between furniture and machinery and carries all its tools with it. The following are its features:

Stainless steel container, which won't rust or deteriorate; large bronze dump valve at the bottom for draining water; big wheels and new type handle that make it highly mobile; by-pass 1¼-hp. motor — 17 gal. capacity — weight of 42-lbs; Master tool with rug, felt, brush and squeegee as slide-on adapters; accordian hose that stretches 16-ft. and made of neoprene.

Your nearest Dustbane branch will supply a demonstration with no obligation.

Vollrath Stainless Steel Soup Cup and Cover

This 10-ounce soup cup is attractively designed for individual tray service. The cover is interchangeable with china soup cups. Cover may be purchased separately. Both cup and cover



Vollrath Soup Cup

are solid stainless steel for permanent beauty, long-range economy and maximum sanitation.

Further information is available from their Canadian distributors, Ingram & Bell Limited, Toronto, and branches.

Mr. and Mrs. T. B. James Married 60 years

Mr. Thomas B. James, president and general manager of the J. F. Hartz Company Limited, Toronto 5, Ontario, and his wife recently celebrated their 60th wedding anniversary by entertaining a number of their immediate friends and Mr. James' business associates at their home.

A party was held recently by the employees at which time they offered their congratulations to the James', and the members of the company's quarter-century club presented a gift to the couple.

Hotel and Restaurant Suppliers Exposition

Montreal will be the focal point of the institutions trade in Canada, January 31st to February 3rd. Assembling then at the Show Mart for the National Hotel, Restaurant & Institutions Exposition will be more than 5,000 hotel

Across the Desk

(Concluded from page 98)

and restaurant operators. owners, dietitians, chefs, club managers, stewards and other lay and religious members.

Together with the Grand Culinary Salon held in conjunction with the National Exposition, suppliers' booths will completely cover the two-acre exhibiting floor of the Show Mart on Berri Street, just north of St. Catherine Street East, in east downtown Montreal.

While the show is open every day to all members of the trade, emphasis will be placed on certain days. January 31st will be Restaurant Day; February 1st, Institutions Day; February 2nd, Hotel Day; February 3rd, Hospital Day.

The Exposition will be open every day from 10 a.m. to 10 p.m. with the exception of the final day when it closes at 6 p.m.

Moffats Presents New Electronic Range

The electronic Raytheon RadaRange, which can cook a potatoe in three

Rada Range

minutes, has been introduced recently into Canada by Moffats Limited. All that is required is to put the food in the RadaRange oven, set the automatic timer and push a button.

Two magnetrons radiate microwaves (2,450,000,000 cycles per second) that enter every part of the food. According to the Company, the food in the RadaRange is not cooked from outside, as in gas or electric heat. Instead, the microwaves penetrate the food, causing the molecules to vibrate at a tremendous speed, creating internal heat in the food itself. Not only is the food cooked to perfection ten times faster than by conventional cooking methods, but it is said to retain up to 17 per cent more of its vitamin content.

The Raytheon Corp., manufacturer of the RadaRange in the U.S.A., has been carrying on preliminary field studies with the RadaRange in a hospital of 90 beds at Walnut Creek, California. According to the Company, the results have been highly successful with complete food control in a simple, efficient ystem. The microwave system converts main kitchen preparation from three daily peak loads to one continuous operation.

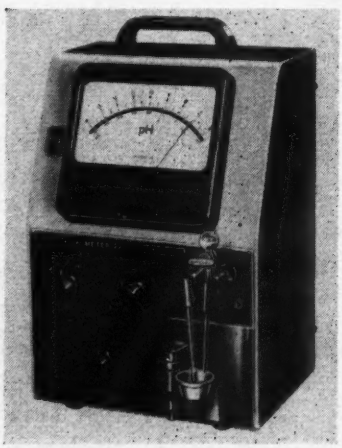
The Company reports the patients are pleased with the quality of the food; the staff appreciates the simplicity of the service and favourable reaction of the patients; and the hospital board the savings in labor.

The RadaRange is exclusively distributed, installed and serviced in Canada by the Commercial Cooking Division of Moffats Limited, Weston, Ontario.

Astrup Apparatus Introduced

The Radiometer Company of Copenhagen, through their exclusive Canadian agents, Bach-Simpson Limited of London, are making available in Canada for both clinical and research use, the special apparatus designed by Dr. Astrup of Denmark for the accurate determination of blood pH and p^{CO_2}.

This equipment, known as Astrup Apparatus, can be used in conjunction with the famous Radiometer measuring instrument, pHM 22, which in the biological range of 6-8 pH will permit determinations to an accuracy of 0.01 pH.

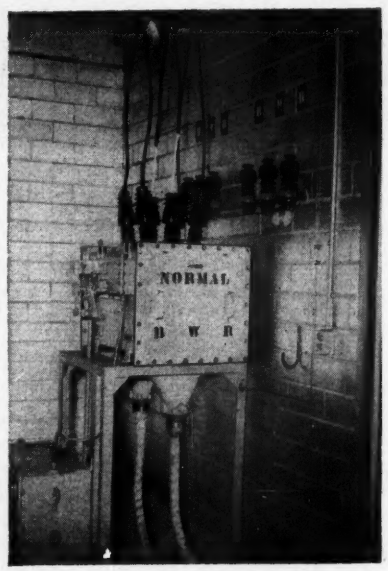


Astrup Apparatus

Astrup Apparatus and Radiometer pH instruments will be distributed nationally by Canadian Laboratory Supplies Limited, as well as the Minneapolis-Honeywell Regulator Company Limited, both of whom have offices in the larger cities in Canada. Descriptive literature is available on request.

Automatic Oil Transfer Switch

Power interruptions to a hospital can have drastic and sometimes tragic consequences. Emergency supply, moreover, means more than just power for a few battery operated lights. In one leading Canadian hospital, it means an independent separate feeder which is automatically switched in the event of any trouble in the main feeder.



Powerlite Feeder

An automatic oil transfer switch operates to transfer the load on a sustained short circuit, or a drop of normal feeder voltage to 65 per cent. As soon as normal feeder voltage is restored to 90 per cent, the load is automatically transferred back to the normal feeder. A three-quarter minute delay after initial transfers prevents hunting. The time for the load to be transferred from normal to standby operation is 15 cycles, which prevents transfer due to minor outages of short cycle duration.

The equipment was made by Powerlite Devices Limted, 1870 Davenport Road, Toronto.

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Operating Gowns
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- SPINAL SHEETS
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So efficient — They eliminate line up or waiting for someone to finish drying. Economical dispensers can be located wherever convenient.

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So soft — Brompton individual paper towels provide a fast . . . smooth . . . economical drying medium.

So economical — Save money with *low cost* Brompton paper towels.

Brompton K-20 Kraft Towels — These general service Kraft towels have maximum absorbency and are recommended for general washroom use.

Brompton W-20 White Towels — These white towels are unsurpassed in quality . . . are lint-free . . . soft . . . very absorbent . . . do not fall apart when wet. They can be used as industrial "white-wipes" to wash, polish or clean up anything.

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